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# Understanding Enrollment Trends and Participant Characteristics of the Medicaid Buy-In Program, 2003-2004

***Final Report***

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# EXECUTIVE SUMMARY

Advances in medicine and technology in addition to changes in social attitudes have improved employment opportunities for working-age adults with disabilities. Despite this progress, however, the employment rate among people with disabilities has fallen since the early 1990s (Burkhauser and Stapleton 2004; Stapleton and Burkhauser 2003; Bound and Waidmann 2002; GAO 1998). This trend may be tied, at least in part, to the fact that people with disabilities continue to face a number of barriers to employment, perhaps the most critical of which is inadequate access to comprehensive health coverage. Faced with a "lose-lose" choice between private employer-based health insurance that may not cover needed services and often prohibitively expensive coverage offered in the individual market,[1] people with disabilities who want to work (or work more) have looked to public health care coverage for support.

Unfortunately, the structure of public assistance has only compounded an already untenable situation by creating, albeit inadvertently, a disincentive to work. For example, higher earnings, an otherwise desirable goal, can jeopardize eligibility not only for federal disability benefit payments, but also for Medicaid and Medicare. The resulting Catch-22 has encouraged some people with disabilities to sacrifice higher wages in return for remaining eligible for public assistance (Stapleton and Tucker 2000).

The Medicaid Buy-In program is an important component of the federal effort to make it easier for people with disabilities to work without losing health benefits. Authorized by the Balanced Budget Act of 1997 and the Ticket to Work and Work Incentives Improvement Act of 1999, the Buy-In program allows states to expand Medicaid coverage to workers with disabilities whose income and assets would ordinarily make them ineligible for Medicaid. States can also customize their Buy-In programs to their unique needs, resources, and objectives. This flexibility, combined with state-level differences in the traditional Medicaid program, causes the Buy-In program to vary from state to state.

This report, the third in a series of annual reports that describe enrollment and participation in the Buy-In program, presents a profile of the Buy-In program in the 28 states that had both a Buy-In program and a Medicaid Infrastructure Grant (MIG) in 2004.

[1] Hadley and Reschovsky (2003) found that, relative to individuals in excellent health, those with major health problems pay 43 to 50 percent higher premiums for nongroup insurance.

Drawing heavily on the first two reports (White et al. 2005 and Ireys et al. 2003), the profile covers the following areas:

- Enrollment
- Participation in other benefit and health insurance programs
- Participants' earnings
- Participants' premiums
- Participants' Medicaid expenditures

Two main data sources are the basis for the analyses in this report: annual state reports on Buy-In participation, which each state completed using their own data sources, and telephone discussions with Buy-In personnel. These discussions were designed to clarify the reasons behind changes documented in the states' reports from one year to the next and, where possible, to identify the reasons driving differences in outcomes across states.

## BUY-IN PROGRAM FEATURES AND THE OVERALL STATE MEDICAID CONTEXT

Buy-In program enrollment and participation outcomes are the product of program features and the interaction between such features and other means of obtaining Medicaid. The income threshold and asset limit, for example, directly affect the pool of individuals eligible for the program and therefore enrollment patterns and participant characteristics as well. Moreover, enrollment and participation outcomes vary considerably across states as a function of the state-to-state variation in income and asset limits as well as other program features.

Adults with disabilities can enroll in Medicaid through several means other than the Buy-In program. The relative availability of these other ways to obtain Medicaid affects participation In the Buy-In program. Three avenues to Medicaid coverage are: (1) through the SSI program (including the 1619 provisions), which in most states allows automatic eligibility for Medicaid;[2] (2) "poverty-level Medicaid," where states may choose to provide Medicaid eligibility for people with disabilities whose income is below the federal poverty level; and (3) the medically needy program, which allows people with disabilities whose income, after medical expenses are deducted, is below a state-specific threshold.[3] All of these means through which working adults with disabilities can obtain Medicaid coverage

[2] The 1619 provisions extend Medicaid eligibility to SSI beneficiaries whose current earnings make them ineligible for full cash benefits.

[3] The process of deducting medical expenses from income is called "spending down." Individuals whose income is already below the medically needy income threshold do not need to undergo the spend-down process.

influence Buy-In enrollment and participation by affecting the pool of individuals eligible for the program.

## FINDINGS

The findings from our analysis of Buy-In program enrollment and participation fall into the five categories outlined below. One constant theme running through the analysis is that enrollment and participation vary considerably across states.

1. ***Buy-In enrollment continued to grow steadily in 2003 and 2004*** primarily because of growth in existing Buy-In programs rather than the addition of new ones. Enrollment as of December 2004 ranged from 5 in Wyoming to 18,610 in Missouri. Many factors such as eligibility criteria and outreach methods can affect how quickly programs grow. Missouri's decision to eliminate its program as of August 2005 will substantially change the national complexion of the program.

2. ***Most Buy-In participants had experience with other disability-related public programs when they enrolled in the Buy-In program.*** About two-thirds (65 percent) of new Buy-In participants in 2004 were in another Medicaid eligibility group before they enrolled, and about three-fourths (73 percent) were receiving SSDI benefits when they enrolled. In addition, about three-fourths (76 percent) of participants in the fourth quarter of 2004 were dually enrolled in Medicare and the Buy-In program, and a small minority (5 percent) had private coverage. These proportions vary substantially across states—from 30 percent in Missouri to 100 percent in Michigan for prior Medicaid eligibility; from 9 percent in West Virginia to 100 percent in Nebraska for the receipt of SSDI benefits at enrollment; from 10 percent in West Virginia to 94 percent in Michigan for dual enrollment in Medicare; and from 1 percent in Missouri to 30 percent in South Carolina for enrollment in a private plan while in the Buy-In program.

3. ***Earnings were low for many Buy-In participants, but some participants earned competitive wages.*** Earnings for about 4 in 10 (43 percent) Buy-In participants in the fourth quarter of 2004 were reported in their state's Unemployment Insurance (UI) system. We found that, of participants with UI earnings, 32 percent of participants had monthly earnings above the SGA level ($810 in 2004), and 10 percent earned more than $1,600 per month. On the other hand, about 7 in 10 (68 percent) had monthly earnings below the SGA level. This may be due in part to participants' disability severity, which may prevent them from earning more. It is also possible that the SSDI "cash cliff" may be causing some individuals to deliberately keep their earnings below the SGA level to maintain SSDI cash benefits. Average monthly UI earnings among those who had them ranged from $450 in North Dakota to $1,531 in South Carolina.

4. ***Average monthly premiums for Buy-In participants ranged from $13 in Maine to $162 in Utah.*** Twenty-two of the 28 states in the analysis required at

least some Buy-In participants to pay a premium. Overall, less than half (38 percent) of Buy-In participants paid a premium in the fourth quarter of 2004.

5. ***Per member per month (PMPM) Medicaid expenditures ranged from $454 in Michigan to $2,657 in Indiana.*** Overall, PMPM Medicaid expenditures were $1,176 in the fourth quarter of 2004. About half (48 percent) of Buy-In participants had average PMPM expenditures below $500.

## RELATIONSHIP BETWEEN PROGRAM DESIGN AND PARTICIPATION

Buy-In program outcomes are the product of interactions between program features and contextual factors that are sometimes subtle and often complex. It is therefore not possible, based on aggregate data, to isolate the independent effect of one factor. However, aggregate data are useful for exploring relationships between program characteristics, context, and outcomes. The following findings on the outcomes of program enrollment, earnings, and medical expenditures are based on our analysis of the aggregate data and discussions with state personnel.

### Enrollment

**Income and Asset Eligibility Criteria**. Income criteria appear to be associated with program penetration (that is, program enrollment per 100,000 working age state residents). Specifically, program penetration was generally greater in states with a high income threshold, and vice versa. Limits on unearned income appear to be related to penetration rates as well.

**Premium Structure.** A program's premium requirements can directly affect an individual's decision to enroll and thus the overall enrollment level in the program. For example, state personnel in Utah noted that the substantial decrease in enrollment that occurred in late 2002 was a direct response to an increase in premiums.

**Grace Period.** The presence of a grace period appears to be associated with more stable enrollment. Among participants who were ever enrolled in a given year, a larger proportion tended to be continuously enrolled for the entire year in states with a grace period.

**Program Context.** One contextual factor that is likely to strongly affect the pool of individuals eligible for the Buy-In program is the eligibility criteria for other Medicaid groups. A state with a wide range of Medicaid groups through which working people with disabilities could obtain coverage should have lower Buy-In enrollment than a similar state that has a narrow range of eligibility groups. We found some evidence for this relationship.

**Outreach.** By informing eligible people with disabilities, eligibility workers, and the advocacy community about the Buy-In program, outreach efforts appear to affect a program's penetration rate.

### Earnings

**Income Verification.** States requiring participants to document the payment of income or FICA taxes tended to have a higher proportion of Buy-In participants with earnings in the Unemployment Insurance (UI) system.

**Earnings Minimum.** States requiring participants to maintain a minimum earnings level to either enroll or remain in the Buy-In program tended to have average earnings that were higher than most of the other states. [4]

## NEXT STEPS

Our analysis of aggregate-level data is limited to the development of hypotheses based on observed relationships between program outcomes and program characteristics and context. A more rigorous analysis of questions like the ones listed below would provide useful and extensive information for a wide range of stakeholders seeking to evaluate and improve the Buy-In program, including federal and state policymakers and the disability advocacy community. Key questions for future studies include:

- Is the Buy-In program successful in providing a work incentive for people with disabilities?
- How can states use program eligibility criteria to most effectively target particular groups of people with disabilities?
- How does the Buy-In program affect state Medicaid expenditures?
- To what extent does the Buy-In program function as a transition from public to private health insurance?
- How will Medicare's Part D drug benefit affect who enrolls in the Buy-In program?

One way to address these questions is to assemble information on Buy-In participants' enrollment in other public assistance programs, their Medicaid and Medicare expenditures, and their earnings. The ongoing work by CMS to integrate data for Buy-In participants from several sources (such as the Medicaid, Medicare, and Social Security programs) is an important opportunity to gain insight into questions and issues that affect the Buy-In program in particular and adults with disabilities overall.

Standard indices of program performance, however, may not capture critical dimensions of employment for Buy-In participants. Neither hours employed nor total earnings are

[4] These state-imposed requirements in New Mexico, Oregon, and South Carolina are contrary to the BBA and Ticket statutes and CMS regulations.

adequate markers for the importance of work to individuals with disabilities. A comprehensive understanding of the impact of the Medicaid Buy-In program will therefore involve not only a rigorous impact evaluation, but also a process evaluation, which, in giving us insight into the views and experience of program administrators and participants, provides the context in which to interpret the quantitative findings. Both federal and state authorities could collaborate in the design and implementation of such studies at the state level. In many states, interest in the Medicaid Buy-In program is high among state legislators and advocacy groups, and program administrators could address key questions through information gathered in well-designed descriptive or evaluative studies.

# CHAPTER I

# INTRODUCTION

Medical and technological advances and changes in social attitudes have improved employment opportunities for working-age adults with disabilities, but despite this progress, the employment rate among persons with disabilities has fallen since the early 1990s (Burkhauser and Stapleton 2004; Stapleton and Burkhauser 2003; Bound and Waidmann 2002; GAO 1998). Persons with disabilities face a number of barriers to employment, perhaps the most critical of which is inadequate access to comprehensive health coverage. Faced with a "lose-lose" choice between private employer-based health insurance that may not cover needed services and often prohibitively expensive coverage offered in the individual market,[1] people with disabilities who want to work (or work more) have looked to public health care coverage for support.

Unfortunately, the structure of public assistance has only compounded an already untenable situation by creating, albeit inadvertently, a disincentive to work. For example, higher earnings, an otherwise desirable goal, can jeopardize eligibility not only for federal disability benefit payments, but also for Medicaid and Medicare. The resulting Catch-22 has likely encouraged some people with disabilities to sacrifice higher wages in return for remaining eligible for public assistance (Stapleton and Tucker 2000).

Federal initiatives during the last two decades have attempted to address this problem. For example, the Americans with Disabilities Act (ADA) of 1990 prohibits employers from discriminating against people with disabilities in the workplace (EEOC 2005). And, the President's New Freedom Initiative sought to "…better integrate [persons with disabilities] into the workforce" (U.S. White House 2005). The Ticket-to-Work and Work Incentives Improvement Act (Ticket Act) of 1999 was designed to promote employment among people with disabilities by making health coverage as well as rehabilitation and employment services more available (SSA 2005a).

The Medicaid Buy-In program is an important component of the federal effort to make it easier for people with disabilities to work without losing health benefits. First passed in

[1] Hadley and Reschovsky (2003) found that, relative to individuals in excellent health, those with major health problems pay 43 to 50 percent higher premiums for nongroup insurance.

1997, the Buy-In program allows states to expand Medicaid coverage to workers with disabilities whose income and assets would ordinarily make them ineligible for Medicaid. States can also customize their Buy-In programs according to their unique needs, resources, and objectives. This flexibility, combined with the differences in traditional Medicaid programs among states, causes Buy-In programs to vary from state to state.

The Centers for Medicare & Medicaid Services (CMS) is monitoring state Medicaid Buy-In programs by tracking enrollment trends, patterns of participation, and the relationship between Buy-In participation and administrative features of other public assistance programs. Specifically, CMS is reviewing the program with respect to the following features:

- The number of individuals entering the program
- The number of participants who received Medicaid before enrolling in the Buy-In program
- Participation in other benefit and health insurance programs
- Participants' earnings
- Participants' premium payments
- Participants' Medicaid costs

The purpose of this report is to provide CMS with comprehensive information on these program dimensions. Each chapter addresses a key policy question about the characteristics of Buy-In participants and describes important ways in which the program structure may affect enrollment and participant characteristics. The report builds on and strategically extends the information presented in White et al. (2005), which was based on data provided by the states for calendar years 2002 and 2003.

## A. DATA SOURCES AND QUALITY

The analyses documented in this report are based on data collected from the following 28 states with a Buy-In program: Alaska, Arkansas, California, Connecticut, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Massachusetts, Michigan, Minnesota, Missouri, Nebraska, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Oregon, Pennsylvania, South Carolina, Utah, Vermont, Washington, West Virginia, and Wisconsin. Each of these states also has a Medicaid Infrastructure Grant (MIG), funded annually by CMS to provide states with $500,000 to $1.5 million specifically to augment their Medicaid programs in a way that encourages competitive employment of individuals with disabilities.

The analysis was restricted to the 28 states with both a Buy-In program and a MIG because only states with a MIG were required to submit the data analyzed in this report. [2]

## 1. Data Sources

Of the four data sources used in this analysis of Buy-In programs, the two main ones are the annual state reports on Buy-In participation in a given calendar year submitted to CMS from May through August 2005 and telephone discussions with Buy-In personnel that MPR conducted during the same time frame. The other two included quarterly progress reports submitted by states to CMS as part of their MIG (used to update our information on Buy-In program policies and enrollment) and other reports and studies on the Buy-In program, including those conducted by states. Based on our review of all the data, we developed profiles of each state's Buy-In program, which appear in Appendix A.

### a. Annual State Reports on Buy-In Participation

The annual state reports on program participation provide aggregate-level data on enrollment measures, Medicaid eligibility prior to enrollment in the Buy-In program, Social Security Disability Insurance (SSDI) status at enrollment, health coverage in addition to Medicaid, premium payments, earnings, and Medicaid expenditures. Twenty-eight states submitted an annual report for calendar year 2004, as did 22 states for 2003 and 21 states for 2002.[3] Most of the reports are based on data from state Medicaid Management Information System (MMIS) files, billing and collection records, and unemployment insurance (UI) data systems. Appendix C includes both the data source used by each state for each item in the annual report and a chart identifying data elements that states were unable to provide.

CMS's rationale for requesting earnings data from state UI systems was to ensure that the data would be comparable across states for analytic purposes. UI data are consistent across states and are provided by employers, who are required in all states to report quarterly information on employment and wages to state Employment Security Agencies. These employers include private firms, state colleges, hospitals, and state and local governments. The UI system (including the associated Unemployment Compensation for Federal Employees) covers over 99 percent of private sector employment (Hiles 2001). However, coverage for any specific state can be less extensive, depending on the composition of its workforce.

Although state UI systems include standard data for most working individuals and nearly all individuals who are competitively employed, the earnings data are not entirely complete because the systems do not include information on several noteworthy groups,

[2] Although Nevada and Wyoming have a Buy-In program and a MIG, they were not included in the study because of low enrollment in both programs—only 7 and 5, respectively, at the end of 2004. The only two remaining states with a Buy-In program—Arizona and Mississippi—do not have a MIG and are thus not included in this report.

[3] Appendix D contains the raw data that states submitted in their annual reports from 2002 through 2004.

including self-employed workers, most workers on small farms, all members of the Armed Forces, elected officials in most states, most employees of railroads, some domestic workers, most students who work in schools, employees of certain small nonprofit organizations, individuals working in a different state, and people working in sheltered workshops or in vocational rehabilitation programs. States also do not have access to earnings for individuals who are paid in cash for work not typically covered by unemployment insurance, such as babysitting and participating on consumer advisory panels. We partially address these shortcomings by analyzing information on self-employment earnings in some states. In addition, the individual-level earnings data that MPR is currently analyzing for a future report will include self-employment earnings data.

Finally, because the UI system is based on positive reporting of earnings, it is not possible to distinguish between individuals who have no earnings and individuals who have earnings that are not reported to the UI system. Thus, the states are likely to over-count individuals with zero earnings but are not likely to miss individuals with substantial earnings.

### b. Telephone Discussions with State Personnel

After states submitted their annual reports in 2004 and 2005, MPR contacted Buy-In personnel in each state to discuss its annual report and Buy-In program. The discussions were designed to clarify the reasons behind changes in a given state's reports from one year to the next and, where possible, to identify the factors behind differences in program outcomes across states. We selected state personnel on the basis of their expertise in two areas: (1) an understanding of the data collection and data reporting processes in their state and (2) overall familiarity with Buy-In policies and the program's relationship to Medicaid and other state programs for individuals with disabilities.

## 2. Data Quality

Overall, the information required in the annual report has been constant since the 2002 reporting year, thereby allowing for the same kinds of data elements to be collected over time and minimizing the burden on state staff. The quality of data submitted by the states has generally improved over the years as personnel became better acquainted with the process. On the other hand, turnover in state staff appears to have added to the time required to prepare the report as new personnel brought themselves up to speed on the reporting process. Also, according to state personnel, unexpected changes in a given measure over time are occasionally due to the use of a different data source or methodology, which affects the comparability of data from one year to the next.

Despite the states' best efforts to improve the reporting process and the experience that did, in many cases, drive that improvement, some errors in the data are inevitable, and one purpose of the telephone discussions was to identify these errors. Some are expected because each of the 28 study states uses its own process to extract information from their data sources. However, state staff were generally willing to help resolve any inconsistencies, and when they had concerns about data accuracy, we included this information in the notes accompanying the tables and figures in this report. Without a separate and comparable data

source against which to reconcile the information submitted by states, however, it is not feasible to identify additional errors. Nonetheless, only the most accurate state data available to date were used in our analysis.

## B. OVERVIEW OF THE REPORT

Chapter II of this report provides the policy context for the Medicaid Buy-In program, including a discussion of the various ways in which people with disabilities can obtain Medicaid coverage. Chapter III lays out the relationship between salient program features and Buy-In participation, and Chapter IV describes recent policy changes in the Buy-In program. The following questions about participation in the Buy-In program that lie at the heart of our analysis are addressed, respectively, in Chapters IV through VIII:

- Is the Buy-In program growing?
- Who participates in the Buy-In program?
- How much are Buy-In participants earning?
- How much are participants' premiums?
- What are Buy-In participants' Medicaid expenditures?

Each chapter begins with an overview of findings at the national level and then examines the extent to which program outcomes vary across states. We conclude with a summary of the main findings and of the key policy questions related to future program monitoring and evaluation.

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# CHAPTER II

# PROGRAM STRUCTURE AND CONTEXT

## A. AUTHORIZING LEGISLATION

In authorizing the Medicaid Buy-In program, the Balanced Budget Act of 1997 (BBA) and the Ticket to Work and Work Incentives Improvement Act of 1999 (the Ticket Act) made Medicaid coverage available to workers with disabilities who were otherwise ineligible because of income or assets. By raising income and asset eligibility levels, both laws allow low-income adults with disabilities to retain their health care benefits as their earnings rise, thus reducing the disincentive to work otherwise present in Medicaid and other public assistance programs.

Under the BBA, states can add a Buy-In program to their regular Medicaid program by creating a new eligibility group for adults with disabilities who are working but do not qualify for Medicaid because their income or assets are too high. Eligibility is based on two financial criteria: (1) net family income must be less than 250 percent of the federal poverty line after the appropriate income disregards are applied (GAO 2003),[1] and (2) an individual's monthly countable unearned income must be less than the benefit amount for the Supplemental Security Income (SSI) program ($564 per month for an individual in 2004) (SSA 2005a).

Under the Ticket Act, states can establish their own income and asset standards, including having no income limits at all (GAO 2003)—this is the Basic Coverage Group. The Ticket Act also adds a new eligibility group termed the Medical Improvement Group. This group covers individuals who lose eligibility under the Basic Coverage Group because they have a medical condition that has improved to the point at which the Social Security Administration (SSA) determines that he or she no longer has a disability.[2] Although six

[1] The BBA requires states to apply the same income disregards as the SSI program when determining Buy-In eligibility, but states are allowed to institute additional income disregards (for example, income for home repair). In addition, the ability of states to use methodologies other than that used for SSI recipients to determine countable income gives states added flexibility with regard to the income threshold (GAO 2003). States also are allowed to determine how a "family" is defined. For example, some states choose to include spousal income when calculating family net income, and other states do not.

[2] For more information see http://www.cms.hhs.gov/twwiia/eligible.asp.

states are authorized to have a Medical Improvement Group, no state had more than 12 enrollees in this group as of September 2005.[3]

Although eligibility for the Buy-In program requires that individuals be working, neither the BBA nor the Ticket Act establishes, or allows states to establish, a minimum number of hours worked in a given period.[4] The one exception is the state of Massachusetts, which requires Buy-In participants to work at least 40 hours per month. Massachusetts was able to define work because it implemented its Buy-In program through an 1115 Medicaid demonstration waiver in 1997, freeing the state from the Buy-In guidelines in both the BBA and the Ticket Act.[5]

By the end of 1999, eight states had implemented the program, and that number more than tripled by December 2002, bringing the total number of Buy-In programs to 25 by the end of that year. In 2003, two more states (Arizona and New York) initiated a Buy-In program, and five states had done so as of December 2004 (Louisiana, Michigan, Nevada, North Dakota, and West Virginia), bringing the total number of programs to 32.

As mentioned in Chapter I, we focused on the 28 states that had both a Medicaid Buy-In program and a MIG in 2004. Twelve of the 28 originally implemented the program under the authority of the BBA, 15 did so under the authority of the Ticket Act, and one did so through a Section 1115 demonstration waiver (Table II.1).

## B. The Buy-In Program and Other Means to Medicaid Coverage: Interactions and Trade-Offs

In addition to a Medicaid Buy-In program, states offer working persons with disabilities who are living in the community several ways to qualify for Medicaid. These additional means of obtaining Medicaid include SSI program participation and the 1619(a) and 1619(b) provisions of the Social Security Act; the medically needy program, and the poverty-level option. This chapter describes these means of obtaining coverage and compares them with the Buy-In program in terms of their advantages and disadvantages for working adults with disabilities and states alike. Table II.2 summarizes eligibility information on these and other means of obtaining Medicaid.

[3] As of September 2005, Pennsylvania had 12 enrollees in the Medical Improvement Group, Kansas had three, Connecticut had two, West Virginia had one, and New York and Washington did not have any.

[4] The Ticket Act allows states to define work for individuals in the Medical Improvement Group. States can either adopt the definition of work provided in the legislation (i.e., a minimum of 40 hours per month) or use their own definition.

[5] Section 1115 of the Social Security Act gives the Secretary of the Department of Health and Human Services authority to waive aspects of the federal Medicaid law to permit states to undertake special research and demonstration projects.

**Table II.1. Buy-In Program Characteristics in the 28 Study States**

| State | Federal Authority | Implementation Date |
|---|---|---|
| Massachusetts | 1115 Waiver | July 1997 |
| South Carolina | BBA 1997 | October 1998 |
| Oregon | BBA 1997 | February 1999 |
| Alaska | BBA 1997 | July 1999 |
| Minnesota[a] | TWWIIA Basic | July 1999 |
| Nebraska | BBA 1997 | July 1999 |
| Maine | BBA 1997 | August 1999 |
| Vermont | BBA 1997 | January 2000 |
| New Jersey | TWWIIA Basic | February 2000[b] |
| Iowa | BBA 1997 | March 2000 |
| Wisconsin | BBA 1997 | March 2000 |
| California | BBA 1997 | April 2000 |
| Connecticut | TWWIIA Basic and Medical Improvement | October 2000 |
| New Mexico | BBA 1997 | January 2001 |
| Arkansas | TWWIIA Basic | February 2001 |
| Utah | BBA 1997 | July 2001 |
| Illinois | TWWIIA Basic | January 2002 |
| Pennsylvania | TWWIIA Basic and Medical Improvement | January 2002 |
| Washington | TWWIIA Basic and Medical Improvement | January 2002 |
| New Hampshire | TWWIIA Basic | February 2002 |
| Indiana | TWWIIA Basic | July 2002 |
| Kansas | TWWIIA Basic and Medical Improvement[c] | July 2002 |
| Missouri | TWWIIA Basic | July 2002 |
| New York | TWWIIA Basic and Medical Improvement | July 2003 |
| Louisiana | TWWIIA Basic | January 2004 |
| Michigan | TWWIIA Basic | January 2004 |
| North Dakota | TWWIIA Basic | May 2004 |
| West Virginia | TWWIIA Basic and Medical Improvement | May 2004 |

Source: Quarterly reports submitted to CMS.

Note: States are sorted in ascending order of their date of first enrollment. BBA is the Balanced Budget Act of 1997. Ticket Act is the Ticket to Work and Work Incentive Improvement Act. Although Nebraska and Wyoming both had a Medicaid Infrastructure Grant and a Medicaid Buy-In program in 2004, we did not include them in this report because they had only seven and five enrollees, respectively as of December 2004.

[a]Minnesota's program was initially approved under the BBA 1997.
[b]New Jersey's program began processing applications in February 2001.
[c]Kansas added its Medical Improvement Group in February 2005.

**Table II.2. Summary of Means of Obtaining Medicaid Eligibility**

| Category of Coverage | Summary of Eligibility Criteria |
|---|---|
| **Mandatory Coverage** | |
| SSI recipients | In 39 states and the District of Columbia, SSI recipients are automatically eligible for Medicaid.[a] |
| 209(b) category[b] | States can use eligibility criteria for individuals who are aged, blind, and disabled that are more restrictive than the SSI program. State establishes a definition of disability and income and asset standards. These "209(b)" states are required to allow persons with disabilities to "spend down" to Medicaid eligibility by deducting incurred medical expenses from their income. A spend down program is operationally similar to the medically needy program described below. |
| SSI 1619(b) provision | Persons with disabilities who were receiving SSI cash benefits and continue to meet all SSI eligibility requirements, except for excess earnings, and whose income is insufficient to replace SSI, Medicaid benefits, and other social services they would have received in the absence of their earnings. |
| Welfare and poverty provisions | Pregnant women and low-income families with children who satisfy state-specific financial eligibility requirements. |
| Coverage for certain Medicare beneficiaries | States are required to extend limited Medicaid benefits (i.e., paying part or all of a person's cost-sharing obligation to Medicare) to low-income individuals who also qualify for Medicare.[c] |
| **Optional Coverage**[d] | |
| Medicaid Buy-In | Working persons with disabilities with income and asset eligibility criteria set by the state. |
| State supplementary payments recipients | Persons with disabilities receiving state supplementary payments to the federal SSI benefit. |
| Medically needy | Individuals whose income either falls below a state-specified threshold or have sufficient medical expenses that allow them to "spend down" to the state-specific income threshold. Assets also must be within the state-specific limit for the medically needy program. |
| Poverty-level coverage[e] | Persons with disabilities with income above that required for mandatory coverage but below the federal poverty line. |

[a]The 1619(a) provision of the Social Security Act allows SSI recipients to continue receiving cash benefits at a reduced level when their countable earned income exceeds the substantial gainful activity (SGA) level ($810, $830, and $860 for the years 2004, 2005, and 2006 respectively) until earnings reach a level where the SSI benefit is reduced to zero. Medicaid eligibility continues until SSI cash benefits cease. In this report, the term "SSI recipients" includes individuals receiving Medicaid benefits under the 1619(a) provision.

[b]States may set their own Medicaid eligibility criteria and definition of disability for individuals with disabilities as long as these criteria are not more restrictive than those in effect as of January 1, 1972. These states are often called "209(b)" states. The following states included in this study have opted to use 209(b) provisions: Connecticut, Illinois, Indiana, Minnesota, Missouri, North Dakota and New Hampshire (GAO 2003).

[c]States are required to cover these groups with limited benefits but QMBs and SLMBs (see below) may also receive full benefits if they qualify under some other eligibility group. These

groups include: (1) a Qualified Medicare Beneficiary (QMB), for whom Medicaid will pay all of Medicare Part A and Part B expenses if the individual has income equal to or less than 100 percent of the FPL and assets less than $4,000 ($6,000 for a couple); (2) a Specified Low-Income Beneficiary (SLMB), for whom Medicaid will pay the Medicare Part B premium if the individual has income between 100 and 120 percent of the FPL and assets less than $4,000 ($6,000 for a couple); (3) a Qualifying Individual (QI) with assets less than $4,000 ($6,000 for a couple), for whom Medicaid will pay all of the Medicare Part B premium if the individual has income between 120 and 135 percent of the FPL and part of the Medicare Part B premium if the individual has between 135 and 175 percent of the FPL; and (4) a Qualified Disabled and Working Individual (QDWI), for whom Medicaid will cover a portion of the Medicare Part A premium if a person with disabilities has income less than 200 percent of the FPL and assets less than $4,000 ($6,000 for a couple) (Schneider et al. 2002). A person cannot be eligible for QI or QDWI if he or she is otherwise eligible for full Medicaid benefits.

[d]In addition to the optional coverage groups listed in this table, states may choose to provide coverage to low-income individuals with tuberculosis or who are uninsured and have been determined to need treatment for breast or cervical cancer.

[e]Section 1902(r)(2) of the Medicaid statute allows states to use less restrictive income and resource methodologies when determining Medicaid eligibility to cover aged or disabled individuals with income below the FPL.

### 1. SSI Program Participation and the 1619(a) Provision of the Social Security Act

SSI provides cash benefits to individuals with disabilities who have little or no income, few assets, and a work history that is insufficient for SSDI eligibility.[6] The benefits are intended to help these people meet the most basic of human needs: food, clothing, and shelter. SSI recipients are automatically eligible for Medicaid in most states. Some states (called "209(b) states") have established criteria for disability and Medicaid eligibility that are more restrictive than the SSI criteria.

The 1619(a) provision of the Social Security Act allows SSI recipients to remain eligible for Medicaid even though their countable earned income exceeds the SGA level (that is, $810 in 2004) and qualifies them for reduced SSI payments. When SSI cash benefits cease because of excess countable earned income, individuals may be eligible for Medicaid through the 1619(b) provision (see below).

### 2. The 1619(b) Provision of the Social Security Act

Under the 1619(b) provision, states must provide Medicaid coverage to "qualified severely impaired individuals," defined as workers who remain disabled but whose earnings are not high enough to replace the SSI, Medicaid benefits, and other social services they

[6] It is possible for a person with disabilities to qualify for SSI and SSDI simultaneously if, for example, that person's assets are within the SSI limit and their SSDI benefit is low enough so as not to push his or her income beyond the SSI threshold.

would have received absent their earnings (SSA 2005b).[7] Each state has its own 1619(b) income threshold, but an individual whose income exceeds this threshold may ask the Social Security Administration to make an eligibility determination that accounts for his or her unique circumstances.

The 1619(b) provision and the Medicaid Buy-In program have similar objectives in that they both promote work by allowing persons with disabilities to retain health coverage as their earnings rise. However, the Buy-In program has two distinct advantages over the 1619(b) provision. First, under the Buy-In program, individuals are eligible for Medicaid benefits regardless of prior SSA status, whereas the 1619(b) provision provides coverage only for those who once received SSI benefits. Second, Buy-In programs typically have higher income and asset limits than the 1619(b) provision and therefore are more likely to attract a larger number of workers with disabilities (Goodman and Livermore 2004).

For some individuals, however, obtaining Medicaid coverage through the 1619(b) provision is preferable to doing so through the Buy-In program for two reasons. First, Buy-In programs typically charge a premium for Medicaid coverage, but the 1619(b) provision has no cost-sharing requirements. Some individuals may therefore be better off keeping their earnings low enough to qualify for the 1619(b) provision if an anticipated earnings increase would not offset what they would pay in a premium for the Buy-In program. Second, all states are required to provide Medicaid eligibility through the 1619(b) provision, thus making the coverage more portable across states than is coverage through a Buy-In program, since not all states offer the program and in those that do, the eligibility criteria vary from state to state.[8] In fact, if a person with disabilities is eligible for Medicaid through SSI, 1619(a) or 1619(b), all of which are mandatory groups, then he or she is ineligible for the Buy-In program, which is an optional eligibility group.

### 3. Medically Needy Programs

Medically needy programs, the third means through which adults with disabilities can obtain Medicaid coverage, allow states to extend Medicaid eligibility to adults with disabilities whose income or assets exceed the financial eligibility criteria for the SSI program. Under the programs, medical expenses for adults with disabilities must be deducted from their income when determining eligibility (the "spend-down" process). A person's income (minus incurred medical expenses) and assets must be at or below the medically needy income and asset levels set by the state. Individuals with income below the medically needy threshold need not spend down their income to be eligible. Despite the flexibility offered by medically needy programs, they intrinsically discourage attempts to earn more money because all income above the medically needy income limit is subject to the spend-down provisions. As

[7] For more information about the 1619(b) provision and other SSI work incentives see http://www.ssa.gov/work/ResourcesToolkit/redbook_page.html.

[8] The income threshold for Medicaid eligibility through 1619(b) also differs across states, but state-specific differences among Buy-In programs are more substantial. Chapter III provides a more detailed discussion of the dimensions along which Buy-In programs vary.

a result, the more a person earns, the more he or she has to spend down to qualify for Medicaid.

In 2005, 32 states and the District of Columbia had a medically needy program that covered adults with disabilities. In addition, the 11 states that can use rules that are more restrictive than SSI to determine eligibility for individuals who are aged, blind, and disabled (the 209(b) states) must allow all persons with disabilities to spend down their income to the Medicaid eligibility level.[9] In these states, the spend-down program is operationally similar to medically needy programs in other states. Both programs allow adults with disabilities to deduct medical expenses from their income when Medicaid eligibility is determined. We therefore use the term "medically needy program" in the remainder of this report to refer to both the medically needy and the spend down program.

The medically needy program is an important option for adults with disabilities because it bridges the coverage gap for many SSDI beneficiaries whose income prevents them from qualifying for SSI benefits or Medicaid coverage. Through the medically needy program, a state makes Medicaid available to adults with disabilities regardless of their income level, assuming that they satisfy the applicable spend-down and asset requirements. Even so, the Buy-In program may be more attractive to these individuals for two reasons. First, the Buy-In program lowers out-of-pocket costs if the monthly premium is lower than the spend-down amount. And second, the program allows participants to avoid the onerous process of documenting spend-down expenditures.[10]

### 4. Poverty-Level Options

Finally, adults with disabilities can qualify for Medicaid through other optional and mandatory eligibility groups. For example, adults with disabilities in some states are eligible for Medicaid if their income is at or below the federal poverty line. States also extend limited Medicaid benefits (i.e., paying part or all of a person's cost-sharing obligation to Medicare) to low-income individuals who qualify for Medicare. Other individuals may qualify through the welfare and poverty provisions that established coverage for low-income families and pregnant women.

## C. THE BUY-IN PROGRAM AND OTHER MEANS TO MEDICAID COVERAGE: DECISIONS

The advantage of the Medicaid Buy-In program over other means through which working adults with disabilities can obtain Medicaid coverage is that it generally allows individuals to keep their health benefits without giving up higher earnings, more assets, or both. In so doing, the program holds promise as the first step on the road to economic independence, especially for the following groups of workers:

[9] 209(b) states that choose to have a medically needy program are not required to have a spend-down program.

[10] The frequency with which individuals are required to undergo the spend-down process varies by state and ranges from one to six months (Schneider et al. 2002).

- SSDI/Medicare beneficiaries who have to spend down to qualify for Medicaid
- SSDI beneficiaries in the waiting period for Medicare
- SSI beneficiaries whose income and assets exceed 1619(b) limits
- Individuals not receiving Medicaid or SSI who would otherwise fit the SSA disability definition were it not for income or assets that exceed the disability benefits eligibility threshold

The various means of obtaining Medicaid coverage can be confusing to individuals with disabilities and state intake workers alike. The very flexibility created by these options is the source of the trade-offs that, however obscure, should be considered if adults with disabilities are to obtain the coverage that is best for them. For example, adults with disabilities may find themselves choosing among (1) spending down to become eligible through the medically needy program, (2) keeping earnings below the 1619(b) income threshold to receive Medicaid benefits without having to pay a premium, or (3) enrolling in the Buy-In program and paying a premium.

These tradeoffs can be particularly difficult to navigate for those who have the most to gain from understanding them: working adults with disabilities who want to earn more but are reluctant to try for fear of jeopardizing their health care coverage. The next chapter discusses how Buy-In program features affect the types of people who enroll.

# CHAPTER III

# PROGRAM FEATURES AND RECENT POLICY CHANGES: HOW THEY SHAPE BUY-IN PROGRAM PARTICIPATION

The federal Buy-In legislation gave states considerable control over the program features that they adopt. States make a series of complex decisions during the design and development of a Buy-In program. They tailor the program to their unique environment and thereby influence program size, enrollment composition, and cost. The most important program features that affect Buy-In participation are (1) income and asset eligibility criteria, (2) premium and cost-sharing structures, (3) work-related policies and protections, and (4) outreach methods. These features do not operate in isolation. Instead, interactions among features occur in subtle, often complex ways to shape Buy-In participation.

Furthermore, as Buy-In programs mature, federal policymakers, state personnel, and other interested groups have continuing opportunities to examine how programs function and the extent to which they operate as intended. In view of operational experience with the program, changes in a state's economic climate, and other factors, states have taken advantage of the considerable latitude accorded them to alter the features of their Buy-In programs by making key policy changes (see Table III.1). Although only some of these changes are reflected in the data analyzed in this report, as a whole they illustrate how program policies are evolving.

In this chapter, we describe the four types of program features, the effect each one can have on participation, and related policy changes. In later chapters, we provide details about how program features shape participation based on empirical evidence from the states' annual reports and discussions with state personnel.

## A. INCOME AND ASSET ELIGIBILITY CRITERIA

### 1. How They Shape Participation

Eligibility criteria for the Buy-In program establish parameters for the number and characteristics of enrollees, and states can adjust the criteria to expand or constrain

**Table III.1. Buy-In Program Policy Changes in 2003 through 2005**

| State | Description (effective date) |
|---|---|
| **Eligibility Criteria** | |
| Kansas | Added a Medical Improvement Group (February 2005). |
| Missouri | Eliminated Buy-In program (August 2005). |
| North Dakota | Expanded age range from 18–64 to 16–65 (June 2005). |
| | Increased asset limit to $13,000, allowing $10,000 to be put toward an individual's Plan for Achieving Self-Support and then combined with the $3,000 Medicaid resource threshold (June 2005). |
| Oregon | Decreased asset limit from $12,000 to $5,000 (July 2003). |
| Pennsylvania | Began allowing individuals to become eligible while gathering medical documentation for the disability determination process rather than requiring them to wait until process was completed (October 2004). |
| South Carolina | Excluded 401(k) balances from countable asset total (2005). |
| Vermont | Increased unearned income disregard from $500 of SSDI benefits to all of SSDI and veterans benefits (September 2005). |
| | Increased asset limit from $2,000 for an individual and $3,000 for a couple to $5,000 for an individual and $6,000 for a couple (September 2005). |
| **Premium and Cost-Sharing Structure** | |
| Massachusetts | Modified sliding fee scale to cause premiums to increase more rapidly as income rises. Implemented administrative procedures, such as payment plans, to avoid disenrollment due to financial hardship (March 2003). |
| Minnesota | Instituted minimum monthly premium requirement of $35 (January 2004). |
| New Hampshire | Instituted plan allowing individuals unable to afford premium to pay over three-month period (February 2005). |
| New Mexico | Increased copayment amounts from $2-$25 to $5-$30 (June 2004). |
| Utah | Reduced premium to 15 percent of countable income from a range of 30 to 55 percent of countable income (July 2003). |
| Vermont | Eliminated premium requirement (June 2004). |
| | Increased premiums from $20 to $50 for participants with income between 185 and 225 percent of FPL and from $24 to $60 for participants with income between 225 and 250 percent of FPL (July 2003). |
| **Work-Related Policies and Protections** | |
| Indiana | The first $65 of earned income is disregarded. Therefore, individuals must have earning of more than $65 per month to qualify for the program (October 2005). |

| State | Description (effective date) |
|---|---|
| Minnesota | The first $65 of earned income is disregarded. Therefore, individuals must have earning of more than $65 per month to qualify for the program (July 2004). |
| | The following two groups of people are no longer exempt from the requirement that all individuals demonstrate payment of Medicare, Social Security, and applicable federal and state income taxes: (1) individuals whose employer is not required to withhold these taxes, and (2) self-employed persons not required to pay these taxes under state or federal law (July 2004). |
| | Amended grace period policy to allow enrollees who lose their job involuntarily or are unemployed due to a medical or disability-related condition to remain on the program for up to four months (January 2004). |
| New Hampshire | Instituted requirement that Buy-In applicants must continue working while eligibility is being determined (May 2005). |
| | Buy-In participants must earn at least the federal minimum wage (May 2005). |
| | Grace period for enrollees who become unemployed shortened from 12 to 6 months (May 2005). |
| Oregon | Require earned income of $900 per quarter to be eligible for the Buy-In (May 2003).[a] |
| Vermont | Participants required to demonstrate payment of FICA taxes, Self-Employment Contributions Act (SECA) payments, or a written business plan approved and supported by a third-party investor or funding source (September 2005). |

Source: Input from state personnel.

[a]This state-imposed requirement is contrary to the BBA and Ticket statutes and CMS regulations.

enrollment levels. State Buy-In programs authorized under the BBA must limit eligibility to individuals with net family income less than 250 percent of the federal poverty level (FPL), whereas the Ticket Act does not stipulate an income eligibility ceiling. Nevertheless, programs authorized under either act have considerable flexibility in determining income and asset eligibility requirements, especially through (1) the treatment of earned and unearned income, (2) selection of an income counting methodology, and (3) the treatment of spousal income.

One important tool available to states for controlling which groups are eligible for the Buy-In program is the treatment of earned income (that is, income earned through work) and unearned income (that is, income gained through means other than work such as private pensions, dividends, and SSDI benefits). Depending on the thresholds used by the states, a Buy-In program with a separate unearned income requirement can restrict the number of new Buy-In participants already enrolled in other assistance programs, especially the SSDI program. For example, a state can set a low ceiling on unearned income for the Buy-In program and thereby exclude many SSDI beneficiaries. Ten of the 28 states covered in this report have adopted a separate limit for unearned income.[1]

Selection of an income counting methodology is another instrument that states can use to influence the number and characteristics of individuals eligible for their Buy-In program. Most states use the SSI counting methodology, which calculates countable income as unearned income minus $20 plus one-half of all earned income above $65.[2] The formula restricts enrollment of individuals with high unearned income—primarily SSDI beneficiaries—by giving unearned income twice the weight of earned income. Four states disregard from the calculation at least a portion of unearned income to extend Buy-In coverage to some individuals with high unearned income, which would include SSDI beneficiaries.[3]

States can opt to include or exclude spousal income as countable income. Eighteen of the 28 states count at least a portion of spousal income toward the income eligibility test.[4] In general, the inclusion of spousal income makes it harder for individuals to qualify for the program.

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[1] The 10 states are Alaska, Arkansas, Maine, Nebraska, New Jersey, New Mexico, Michigan, South Carolina, Vermont, and West Virginia.

[2] States that use the SSI counting methodology are required to set a net income limit, that is, a limit on income after the subtraction of SSI deductions (letter from Sally Richardson at CMS to state Medicaid directors, March 9, 1998).

[3] When counting unearned income for Buy-In eligibility determination, California and New Jersey disregard all SSDI benefits and Vermont disregards $500 of SSDI benefits. Nebraska disregards all unearned income for SSDI beneficiaries participating in a trial work period (see Appendix A for more details).

[4] Massachusetts and Minnesota have no income test; therefore, spousal income is irrelevant. Minnesota takes parental income into account when determining eligibility for individuals age 16 or 17 who live with their parents.

For people with disabilities, the Buy-In program is especially attractive because, among its other features, it permits the accumulation of assets or resources beyond the level allowed under SSI and traditional Medicaid, two programs that, in many states, limit an individual's allowable assets to no more than $2,000 plus some exclusions.[5] States can affect the size of the pool of people eligible for the Buy-In program by raising or lowering the asset limit. Several states also permit enrollees to accumulate resources in state-sponsored accounts for medical savings, employment, or independence without losing eligibility for the Buy-In program. States vary in the requirements associated with these accounts.

### 2. Recent Policy Changes

The most dramatic change to eligibility criteria was Missouri's decision to eliminate its Buy-In program as of August 28, 2005. This single change will have an important impact on the complexion of the Buy-In program at the national level because Missouri's 18,610 enrollees constituted approximately one-quarter of national program enrollment as of December 2004. Missouri's decision to eliminate its Buy-In program was part of an overall effort to reduce state expenditures in general and Medicaid costs in particular. State personnel noted that the Buy-In program lost support among legislators because of its high enrollment (and thus high cost) coupled with anecdotal evidence that large numbers of participants were engaged in minimal work efforts and had enrolled primarily to reduce their out-of-pocket expenditures for medical services.

Other changes to eligibility criteria were incremental in nature. For example, Oregon decreased its asset limit, and North Dakota and Vermont increased their limits. In addition, Kansas added a Medical Improvement Group to its program, but the experience of other states with such a group suggests that the change is unlikely to affect many enrollees.

## B. Premium and Cost-Sharing Structures

### 1. How They Shape Participation

Buy-In programs vary widely in their premium and cost-sharing structures. Under federal law, states can require a premium or other means of cost sharing (that is, coinsurance or copayment) from Buy-In participants. Nearly all states have established a premium structure tied to a sliding scale based on income. A premium structure can be an effective tool for states interested in influencing enrollment trends. Decisions about who pays a premium, how much each participant pays, and how premiums change across different income brackets all shape enrollment patterns. One salient feature of the premium structure is the income threshold above which all participants must pay a premium (hereafter, the premium threshold). Participants are less likely to pay a premium when the premium threshold is high.

[5] The SSI asset test excludes the recipient's home, car, household goods, burial plots, term life insurance, and income considered part of a Plan for Achieving Self Support (PASS) (Goodman and Livermore 2004).

Two other key features of a program's premium structure are the amount of the premium payment and the treatment of earned and unearned income for purposes of premium calculations. A Buy-In participant with a high premium shoulders a large financial burden as a condition of remaining in the program and may be less likely to enroll and, if enrolled, more likely to disenroll. High premiums also increase a state's total revenue from the program. If the budget climate for Medicaid continues to erode, some states may increase Buy-In premiums to boost revenue (and discourage enrollment). Some states are instituting a mandatory one-time entry fee for participants who enroll in the program in lieu of or in addition to a premium payment. The fees may increase revenue generated from the program, especially if the state can avoid the costs of premium collection. However, states are limited in their ability to use premiums and other cost sharing to raise revenue because they retain only the state's share of the returns and must turn over the remainder to CMS. For example, if a state has a 50 percent Medicaid match, they must return $50 for every $100 collected in premiums.

Similar to setting rules for income eligibility, a state Buy-In program may implement a separate premium for unearned income in addition to a premium for earned income. In Wisconsin, for example, the premium for Buy-In participants consists of all of unearned income (minus certain disregards) in addition to 3 percent of earned income.

### 2. Recent Policy Changes

Since the end of 2002, three states increased their cost-sharing requirements, one state decreased them, and one state did both. Minnesota now requires a minimum premium of $35, New Mexico has increased its copayment amounts, and Massachusetts modified its sliding fee scale to cause premiums to increase more rapidly as incomes rise. These increased cost-sharing requirements should theoretically make the Buy-In program less attractive to potential enrollees. In 2003, Utah reduced its premium substantially, and Vermont, after increasing premiums in 2003, eliminated its premium requirement the following year because the associated revenue was insufficient to offset the administrative costs of the collection effort. Like Vermont, New Jersey has never collected premiums because of the administrative cost of doing so.

## C. WORK-RELATED POLICIES AND PROTECTIONS

### 1. How They Shape Participation

Some Buy-In participants may have trouble maintaining employment because of health issues, the extensive adjustments that may be required to maintain employment, or difficulty finding jobs that can accommodate their disability. To help prevent interruptions in coverage among Buy-In participants, some states provide protections for program participants by offering a grace period if they either lose a job or cannot work for a period of time because of health problems or an involuntary job loss. The grace period varies by state with respect to both the duration of and criteria for receiving protection. In some states, a participant must be actively seeking employment in order to stay in the program while other states automatically allow an unemployed participant to remain in the program for a set

period of time. Some Buy-In participants who become unemployed would likely be transferred to another Medicaid eligibility group. Whether this results in higher or lower out-of-pocket costs depends on the Buy-In program's premium and cost-sharing structure and the eligibility group to which the person is transferred.[6] For an unemployed participant who is not transferred, however, remaining in the Buy-In program through a grace period would likely be preferable to, for example, losing Medicaid coverage and purchasing coverage in the private market or going without it altogether.

In general, state Buy-In programs do not provide the option of defining what constitutes work by, for example, requiring a person to work a minimum number of hours as a condition of participation. Such a constraint has frustrated program staff in several states that want to limit participation to individuals engaged in a substantial work effort. Some states, however, have implemented policies designed to require a more substantial work effort of Buy-In participants. In South Carolina, for example, Buy-In participants must have earned income of at least $810 (in 2004) per month to enroll and remain in the program. Similarly, New Mexico and Oregon require individuals to earn at least $900 per quarter to enroll. The state-imposed minimum earnings requirements in New Mexico, Oregon, and South Carolina are contrary to the BBA and Ticket statutes and CMS policy.

Buy-In programs typically require workers to document their employment status. Some states ask program participants or their employers to submit verification of employment, such as pay stubs. Certain other states specify that countable earnings must be subject to federal income taxes. In many cases, states chose verification requirements that match the existing requirements for other Medicaid groups. However, some states use verification requirements that differ from those for other groups because of their intent to use the Buy-In as a work incentive program. Illinois, for example, in response to requests from the disability advocacy community that the program require "real work," decided to require demonstration of the payment of FICA tax. In addition, state personnel in Arkansas noted that the Buy-In program was not designed for people performing "minimal" work for a friend or neighbor. Therefore, given that personnel were unable to define work, the state decided to require participants to demonstrate that they report income to the IRS, which is one feature that makes the Buy-In program unique among Medicaid eligibility groups in that state. In contrast, Wisconsin does not require income or FICA tax verification because of a state requirement for the parity of enrollment processes across Medicaid eligibility groups.

Many states offer personal assistance services (PAS) to Buy-In participants.[7] These supports assist people with disabilities in performing, for example, activities of daily living such as eating and transferring, so that individuals can maintain employment in situations

[6] For example, a person who transfers to the medically needy program could pay more out of pocket if he or she is required to spend down to become eligible. On the other hand, someone who transfers to poverty-level Medicaid (where there is no premium or spend-down requirement) could experience lower out-of-pocket costs.

[7] All states with both a Buy-In program and a MIG are required to offer personal assistance services "sufficient to enable individuals to work" or to work toward doing so (CMS 2005c).

where work otherwise would not be possible. Decisions as to which or how often personal assistance services should be covered by a state can have important implications for program enrollment. For instance, if a program has a cap on PAS coverage, some participants may have to limit their work effort.

## 2. Recent Policy Changes

Anecdotal evidence that many participants were engaged in a minimal work effort in order to obtain coverage was reported by state personnel as one reason that Missouri eliminated its Buy-In program. Yet, the issue of participants' work effort is not unique to Missouri. Personnel in some other states also voiced concern that the participation of enrollees with very low earnings was both detrimental to political support for the program and inconsistent with the program's original intent.

Such concern led some states to make policy changes designed to require substantial work among Buy-In participants. One state instituted a minimum earnings requirement that encourages participants either to work more hours or find more competitive employment. In 2003, Oregon began requiring participants to earn at least $900 per quarter to enroll or remain in the program.[8] Two other states—Indiana and Minnesota—revised their eligibility policies to disregard the first $65 of an individual's earned income. Therefore, an individual must have earned income of at least $65 per month to qualify for the program. Personnel in both Indiana and Minnesota noted that the change was designed to promote more "competitive" employment among Buy-In participants, in part by limiting enrollment of people with disabilities with minimal earned income from work in day training and habilitation (DTH) facilities (often called sheltered workshops). Personnel in Indiana and Minnesota reported large numbers of participants who work in DTH facilities before they made this change.[9]

In an effort to increase Buy-In participants' work effort, Minnesota and Vermont revised their income verification requirements. Both states now require all participants, including those in DTH facilities, to demonstrate payment of taxes.[10] The change probably will mean that fewer participants with very low earnings will enroll in these states' Buy-In programs. However, state personnel in Vermont expected that, when they increased the unearned income disregard and eliminated the premium requirement, enrollment would increase. Therefore, to offset any potential enrollment increase, they coupled these changes

[8] This state-imposed requirement is contrary to the BBA and Ticket statutes and CMS policy.

[9] A sheltered workshop is ". . .a controlled environment providing job operations involving a limited set of tasks. . . . Sheltered employment is most frequently used with individuals with severe functional limitations" (GAO 1996).

[10] Vermont does not have any DTH facilities. Before this change, participants in Minnesota were required to demonstrate payment of all applicable state and federal taxes, but participants working in day training and habilitation facilities, who are those most likely to be affected by the requirement, were not.

with the new requirement (described above) that participants demonstrate payment of FICA taxes. [11]

## D. OUTREACH METHODS

When Buy-In programs begin, they have the difficult task of reaching out to eligible persons. Likewise, existing Buy-In programs that hope to attract new individuals face the challenge of determining the most effective methods for ongoing outreach. The type and amount of outreach performed by a state's Medicaid office and disability community appears to relate directly to program enrollment. One-third to two-thirds of Buy-In participants first learn about the program from state eligibility workers (Goodman and Livermore 2004). Therefore, an outreach campaign that trains and educates eligibility workers about the Buy-In program should lead to greater awareness of the program and thus increased enrollment.[12] However, budgetary concerns may make states hesitant to conduct extensive outreach activities that could potentially increase enrollment and thus program costs.

The channels used by states to convey their outreach messages or the messages crafted by the states to reach their intended audiences may influence who learns about the program and is attracted to it. For example, Buy-In personnel in Illinois noted that their outreach strategies include a radio advertising campaign and the use of public service announcements. On the other hand, personnel in Iowa noted that word of mouth was their main reason for enrollment growth and that they had not done any outreach since the program was implemented in 2000. The more active outreach effort in Illinois compared to Iowa may cause the overall characteristics of Buy-In participants to differ in these two states.

[11] Rather than demonstrating payment of FICA taxes, participants in Vermont can also provide evidence of Self-Employment Contributions Act (SECA) payments or a written business plan approved and supported by a third-party investor or funding source.

[12] See Goodman and Livermore (2004) for a discussion of the challenges associated with training eligibility workers and encouraging them to be effective program advocates.

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# CHAPTER IV

# IS THE BUY-IN PROGRAM GROWING?

The number of states participating in state Buy-In programs, along with the states' respective enrollment levels, provides an important indication of the extent to which the program is achieving its goal of supporting the employment of persons with disabilities. Underlying the national trend in Buy-In enrollment are several factors that vary by state. This chapter begins by describing national enrollment trends in the Buy-In program and then outlines how enrollment levels and dynamics vary across states.

## A. NATIONAL BUY-IN ENROLLMENT

Total enrollment in the Buy-In program continued to increase steadily in 2004 from 60,132 in December 2003 to 76,679 one year later, representing a one-year growth rate of 28 percent (see Figure IV.1). The higher enrollment at the end of 2004 was primarily attributable to the growth of existing programs. The five new Buy-In programs in 2004 accounted for only 6 percent of the total enrollment increase.

Figure IV.1 highlights the influence of Missouri's program, which accounted for 24 percent of nationwide enrollment in December 2004. Thus, the state's decision to eliminate the program as of August 28, 2005 will alter the national complexion of the Medicaid Buy-In program.

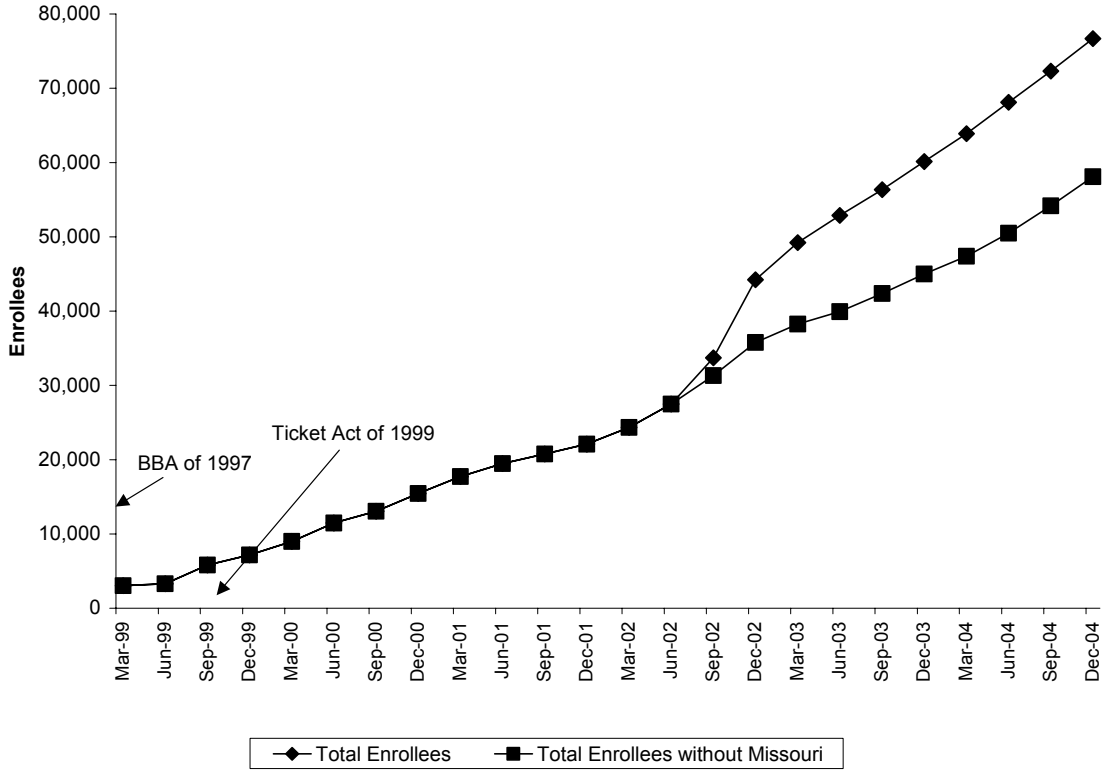
## B. STATE BUY-IN ENROLLMENT

The considerable cross-state variation in Buy-In enrollment ranges from 5 participants in Wyoming as of December 2004 to 18,610 in Missouri. To develop a standard index of enrollment, we calculate Buy-In enrollment per 100,000 state residents age 18 to 64 (hereafter, the penetration rate) (see Table IV.1). The index provides a rough means for comparing the states by accounting for state variation in the size of the working-age population.[1]

[1] We compared this measure to two other measures of the program penetration rate—one based on the number of SSI beneficiaries who work and the other based on the number of SSDI beneficiaries who would be

To facilitate comparisons across states by accounting for population size and a program's maturity, we present Buy-In program penetration one year following program inception. The penetration rate in the first year after inception is likely to reflect program start-up issues and outreach, but we nonetheless focus on this period of time to allow for comparisons across all of the states. Furthermore, rankings were similar when we compared penetration rates one and two years after inception.

**Figure IV.1. Total Enrollment in the Medicaid Buy-In Program, 1999–2004, 32 States**




(*continued*)
eligible for other Medicaid eligibility groups without spending down. Appendix Table D.4 demonstrates that the rankings of states were generally similar across these measures.

**Table IV.1. State Buy-In Enrollment**

| State | Implementation Date | Buy-In Enrollment, December 2004 | Buy-In Enrollment per 100,000 State Residents Age 18 to 64 | |
|---|---|---|---|---|
| | | | December 2004 | One Year Since Inception |
| Missouri | July 2002 | 18,610 | **516** | 364 |
| Iowa | March 2000 | 7,695 | **418** | 111 |
| Wisconsin | March 2000 | 7,713 | **221** | 28 |
| Minnesota | July 1999 | 6,165 | **190** | 164 |
| Massachusetts[a] | June 1997 | 7,520 | **184** | 54 |
| Indiana | July 2002 | 6,117 | **158** | 119 |
| Connecticut | October 2000 | 3,365 | **154** | 75 |
| New Hampshire | February 2002 | 1,268 | **151** | 119 |
| Vermont | January 2000 | 520 | **128** | 59 |
| New Mexico | January 2001 | 1,181 | **100** | 45 |
| Maine | August 1999 | 644 | **76** | 42 |
| North Dakota | May 2004 | 258 | **64** | 64[b] |
| Pennsylvania | January 2002 | 4,865 | **63** | 17 |
| Kansas | July 2002 | 823 | **48** | 34 |
| Alaska | July 1999 | 194 | **46** | 14 |
| Oregon | February 1999 | 583 | **26** | 8 |
| New Jersey | February 2000[c] | 1,351 | **25** | 11 |
| New York | July 2003 | 2,480 | **20** | 13 |
| Utah | July 2001 | 260 | **18** | 17 |
| Louisiana | January 2004 | 424 | **15** | 15 |
| Washington | January 2002 | 448 | **11** | 4 |
| Illinois | January 2002 | 656 | **8** | 4 |
| West Virginia | May 2004 | 90 | **8** | 8[b] |
| Nebraska[d] | July 1999 | 67 | **6** | 5 |
| California | April 2000 | 1,165 | **5** | 1 |
| Arkansas | February 2001 | 48 | **3** | 11 |
| Michigan | January 2004 | 140 | **2** | 2 |
| South Carolina | October 1998 | 52 | **2** | 1 |
| Total | | 74,702 | **70** | |

Sources: State data submitted to CMS in quarterly reports, Bureau of the Census (2005).

Note: Calculation of the Buy-In Enrollment per 100,000 state residents age 18 to 64 is based on Bureau of the Census estimates for July 2004. States are sorted in descending order of Buy-In enrollment in December 2004 per 100,000 state residents age 18 to 64. Nevada and Wyoming had enrollments of seven and five, respectively, as of December 2004.

[a]Massachusetts' Buy-In program is the only one authorized through an 1115 Medicaid demonstration waiver. See Appendix A for more information.

[b]Program began in May 2004; therefore, number is calculated in terms of December 2004 enrollment.

[c]New Jersey's program began processing applications in February 2001.

[d]Personnel in Nebraska noted that the December 2004 enrollment number may be incorrect.

## 1. Program Features

### a. Income Threshold

A program's income threshold is one factor that affects the pool of individuals eligible for the Buy-In program. However, ranking states based on the generosity of their income eligibility criteria is difficult. States differ in their income counting methodologies and whether they include spousal income when determining a person's countable income. All else equal, states with lower income thresholds should have larger pools of potential participants and therefore proportionally larger enrollments.

Table IV.2 shows that states with more generous income eligibility criteria—those with no income threshold or with one above 250 percent of FPL (for example, Connecticut, Indiana, Kansas, Massachusetts, Minnesota, and New Hampshire)—tend to cluster at the top of the penetration rate rankings. Conversely, four of the five states with the lowest program penetration rates rely on a countable income threshold of 250 percent of FPL or below. Wyoming had only one enrollee at the end of its program's first year, probably in part because of its low countable income threshold of 100 percent of the FPL at the time.

Notable exceptions, however, highlight the fact that several factors contribute to a program's penetration rate. Missouri, for example, has the highest program penetration rate, but it does not have a high income threshold. Moreover, despite a high income and asset limit, Michigan has a low program penetration rate, which is likely a function of the state's *unearned* income limit and its requirement that all Buy-In participants be enrolled in another Medicaid eligibility category before applying to the Buy-In program.[2]

### b. Asset Limit

Theoretically, it is reasonable to expect a relationship between penetration rates and a program's asset limit—programs with lower asset limits would have lower penetration rates. However, the results in Table IV.2 show otherwise. Missouri and Indiana rank first and third in program penetration despite their relatively low asset limits ($1,000 and $2,000, respectively). Similarly, Washington's and Michigan's penetration rates rank low despite the states' generous limits (that is, no limit and $75,000, respectively). However, as noted above, other factors likely drive enrollment in Michigan and other states.

One possibility for the lack of an observed relationship between penetration rates and asset limits is that many people with disabilities applying for the Buy-In program may have few assets beyond their primary residence, which is typically not counted toward the asset limit. Individual-level information on Buy-In applicants' asset levels are not currently available. However, individual states could potentially use data from their eligibility determination systems to determine how often Buy-In applicants are denied eligibility because of excess resources.

[2] This state-imposed requirement is contrary to the BBA and Ticket statutes and CMS regulations.

**Table IV.2. Program Features Contributing to Buy-In Enrollment Level**

| State | Buy-In Enrollment per 100,000 State Residents Age 18 to 64, One Year since Inception | Rank | Income Threshold (percent of FPL unless otherwise noted) | Individual Asset Limit | Unearned Income Limit |
|---|---|---|---|---|---|
| Missouri | 364 | 1 | 250[b] | $1,000 | |
| Minnesota | 164 | 2 | None | $20,000 | |
| Indiana | 119 | 3 | 350 | $2,000 | |
| New Hampshire | 119 | 4 | 450[a] | $21,370 | |
| Iowa | 111 | 5 | 250[a] | $12,000 | |
| Connecticut | 75 | 6 | $75,000 | $10,000 | |
| North Dakota | 64[d] | 7 | 225 | $10,000 | |
| Vermont | 59 | 8 | 250[a] | $2,000 | Yes |
| Massachusetts[e] | 54 | 9 | None | None | |
| New Mexico | 45 | 10 | 250[a] | $10,000 | Yes |
| Maine | 42 | 11 | 250[a] | $8,000 | Yes |
| Kansas | 34 | 12 | 300[a] | $15,000 | |
| Wisconsin | 28 | 13 | 250[a] | $15,000 | |
| Utah | 17 | 14 | 250[a] | $15,000 | |
| Pennsylvania | 17 | 15 | 250[a] | $10,000 | |
| Louisiana | 15 | 16 | 250 | $25,000 | |
| Alaska | 14 | 17 | 250[a] | $2,000 | Yes |
| New York | 13 | 18 | 250[a] | $10,000 | |
| Arkansas | 11 | 19 | 250 | $4,000 | Yes |
| New Jersey | 11 | 20 | 250[a] | $20,000 | Yes |
| West Virginia | 8[d] | 21 | 250 | $2,000[c] | Yes |
| Oregon | 8 | 22 | 250 | $5,000 | |
| Nebraska | 5 | 23 | 250[a] | $4,000 | Yes |
| Illinois | 4 | 24 | 200[a] | $10,000 | |
| Washington | 4 | 25 | 250[a] | None | |
| Michigan | 2 | 26 | None | $75,000 | Yes |
| California | 1 | 27 | 250[a] | $2,000 | |
| South Carolina | 1 | 28 | 250[a] | $2,000 | Yes |

Source: State data submitted to CMS in quarterly reports, Bureau of the Census (2005), and information from state personnel.

Note: Calculation of Buy-In enrollment per 100,000 state residents age 18 to 64 is based on enrollment one year after the program began and on the Bureau of the Census estimate for July of the corresponding year. States are sorted in descending order of their Buy-In enrollment per 100,000 residents one year after program implementation.

[a]Includes spousal income.
[b]Missouri excludes spousal income unless it is over $100,000.
[c]West Virginia has a $5,000 liquid asset exclusion.
[d]Based on Buy-In enrollment as of December 2004 when the programs in North Dakota and West Virginia had been operating for eight months.
[e]Massachusetts' Buy-In program is the only one authorized through an 1115 Medicaid demonstration waiver. See Appendix A for more information.

### c. Unearned Income Limit

A strict limit on unearned income might result in relatively low enrollment by restricting the number of SSDI recipients eligible for enrollment. The data in Table IV.2 provide some evidence of such a relationship: seven of the ten states with an unearned income limit have penetration rate rankings of 17th or below. Personnel in states with such a limit were generally confident that the limit constrained enrollment. Specifically, the penetration rate in Arkansas decreased by 65 percent in the program's second year, and state staff noted that this was largely attributable to the addition of an unearned income limit, which was coupled with more stringent income verification requirements than those used during the first year of program operation.[3]

### d. Grace Periods and Income Verification Requirements

Two other program characteristics may affect enrollment: grace periods and income verification requirements. In theory, longer grace periods should allow unemployed people with disabilities to remain on the program longer, possibly leading to higher enrollment levels. However, the data collected for this study did not support this relationship. It might also be reasonable to expect a relationship between income verification requirements and enrollment; states with lenient requirements (for example, states that do not require income or FICA tax verification) may allow more people to enroll in the program. Again, the data did not show a consistent link between lenient verification requirements and enrollment levels.

## 2. Contextual Features

The Buy-In program is a single, albeit important, component in what is a complex mosaic of public assistance programs for people with disabilities. As a result, the larger context of medical assistance programs in each state has important implications for the number and type of persons with disabilities who enroll in the Buy-In program. For example, high income thresholds in other Medicaid eligibility categories (for example, the medically needy program, Medicaid through SSI and the state SSI supplement, or other Medicaid eligibility groups) could constrain Buy-In enrollment by narrowing the band of income levels that qualify for Buy-In coverage.

We used the method in Jensen et al. 2002 to develop a proxy indicator for describing the level of restrictiveness in a state's Medicaid context. The proxy measure consists of the highest of the following three income thresholds: (1) the medically needy program, (2) the income standard for the poverty-level Medicaid option, and (3) the combined federal and state SSI benefit. As shown in Table IV.3, the data bear out the relationship to a limited extent. States with high program penetration rates tend to have restrictive income eligibility

[3] Initially, Arkansas did not require Buy-In participants to demonstrate that they were reporting earned income to the IRS, but the state instituted such a requirement during the program's first year.

criteria for other Medicaid pathways. Four of the five states with the highest penetration rate rank 17th or below in terms of their eligibility criteria for other Medicaid pathways. Similarly, three of the five states with the lowest penetration rates rank sixth or higher for the level of restrictiveness for other Medicaid options.

High penetration rates in some states may be partly attributable to large numbers of enrollees who transferred into the Buy-In program from other Medicaid eligibility groups.[4] In Missouri, for example, one reason for the rapid growth of the Buy-In program was a substantial increase in out-of-pocket costs for the state's spend-down program in response to a rule change shortly after inception of the Buy-In program.[5] The increase caused many people enrolled in the spend-down program to transfer to the Buy-In program. Similarly, in Minnesota, the Buy-In premium was generally lower than spend-down amounts for people in its medically needy program, thus providing an incentive to enroll in the Buy-In.

Finally, another key factor affecting Buy-In enrollment is the overall work environment for people with disabilities. The environment reflects a combination of factors, including general economic conditions, the types of available jobs, and the system of employment supports for people with disabilities. Employment supports could include, for example, a network of day training and habilitation facilities, vocational rehabilitation programs, and federal disability-related employment grants such as the Medicaid Infrastructure Grant and the Social Security Administration Disability Program Navigator program that is designed to help people with disabilities gain access to employment-related services.[6]

It would be difficult for a single measure to capture the broad range of factors that contribute to the overall work environment for people with disabilities. However, one indicator that is measured consistently across states and that can serve as a rough proxy for the general work environment for people with disabilities is the percent of SSI beneficiaries who are employed.[7] For instance, one might expect a state with a rich system of employment supports for people with disabilities (for example, vocational rehabilitation programs and sheltered workshops) to have a high proportion of SSI beneficiaries who are employed compared to states with a more limited employment support system for this population. We find a limited relationship between the proxy measure and penetration rates. All five states with the lowest penetration rates rank 14 or below in their percent of

[4] Chapter V provides more detail about the experience of Buy-In participants in Medicaid before Buy-In enrollment.

[5] Missouri's Buy-In program began in July 2002, with rules for the spend-down program changing shortly thereafter in October 2002. Before October 2002, the state did not require individuals in the state's spend-down program to pay the spend-down amount. However, in October 2002, CMS began requiring individuals in the program to pay the spend-down amount themselves, causing out-of-pocket costs to increase substantially.

[6] See http://disability.law.uiowa.edu/dpn/grant/dreg_files/DREG_map.pdf for information on which states have disability-related employment grants.

[7] Goodman and Livermore (2004) used the percent of employed SSI beneficiaries for this purpose as well.

employed SSI beneficiaries, and three of the fives states with the highest penetration rates rank eighth or higher for the same measure.

**Table IV.3. Contextual Features Contributing to Buy-In Enrollment Level**

| | Buy-In Enrollment per 100,000 State Residents Age 18 to 64 Year since Inception | | Highest Income Eligibility Criterion for Other Medicaid Options[a] | | Percent of SSI Beneficiaries Who Work[b] | |
|---|---|---|---|---|---|---|
| | # of Enrollees | Rank | Dollars | Rank | Percent | Rank |
| Missouri | 364 | 1 | 564 | 21 | 6.6 | 16 |
| Minnesota | 164 | 2 | 776 | 6 | 15.4 | 3 |
| Indiana | 119 | 3 | 564 | 21 | 6.3 | 18 |
| New Hampshire | 119 | 4 | 591 | 17 | 10.1 | 8 |
| Iowa | 111 | 5 | 564 | 21 | 16.4 | 2 |
| Connecticut | 75 | 6 | 747 | 14 | 8.4 | 10 |
| North Dakota | 64[c] | 7 | 564 | 21 | 18.8 | 1 |
| Vermont | 59 | 8 | 800 | 5 | 9.8 | 9 |
| Massachusetts[d] | 54 | 9 | 1,032 | 2 | 7.5 | 11 |
| New Mexico | 45 | 10 | 579 | 18 | 4.8 | 25 |
| Maine | 42 | 11 | 831 | 4 | 7.4 | 12 |
| Kansas | 34 | 12 | 564 | 21 | 11.2 | 6 |
| Wisconsin | 28 | 13 | 683 | 15 | 12.1 | 5 |
| Utah | 17 | 14 | 776 | 6 | 10.7 | 7 |
| Pennsylvania | 17 | 15 | 776 | 6 | 5.2 | 22 |
| Louisiana | 15 | 16 | 564 | 21 | 3.6 | 27 |
| Alaska | 14 | 17 | 1,047 | 1 | 6.8 | 14 |
| New York | 13 | 18 | 659 | 16 | 6.0 | 19 |
| Arkansas | 11 | 19 | 564 | 21 | 4.6 | 26 |
| New Jersey | 11 | 20 | 776 | 6 | 6.4 | 17 |
| West Virginia | 8[c] | 21 | 564 | 21 | 2.9 | 28 |
| Oregon | 8 | 22 | 566 | 20 | 7.4 | 12 |
| Nebraska | 5 | 23 | 776 | 6 | 14.5 | 4 |
| Illinois | 4 | 24 | 776 | 6 | 5.9 | 20 |
| Washington | 4 | 25 | 571 | 19 | 5.8 | 21 |
| Michigan | 2 | 26 | 776 | 6 | 6.8 | 14 |
| California | 1 | 27 | 1,026 | 3 | 5.2 | 22 |
| South Carolina | 1 | 28 | 776 | 6 | 5.1 | 24 |

Sources: State data submitted to CMS in quarterly reports, Bureau of the Census (2005), SSA (2005d), and information from state personnel.

Note: Calculation of Buy-In enrollment per 100,000 state residents age 18 to 64 is based on enrollment one or two years after the program began and on the Bureau of the Census estimate for July of the corresponding year. States are sorted in descending order of their Buy-In enrollment per 100,000 residents one year after program implementation.

**Table IV.3 (*continued*)**

[a]The highest income eligibility criterion for other Medicaid categories involves taking the highest of the (1) income threshold for the medically needy program, (2) the income standard for the Medicaid poverty-level option, and (3) the combined federal and state SSI benefit.

[b]Calculated as the number of blind and disabled SSI recipients who work (including Section 1619(a) and 1619(b) recipients) divided by the total number of blind and disabled SSI recipients. (SSA 2005d).

[c]Based on Buy-In enrollment as of December 2004 when the programs in North Dakota and West Virginia had been operating for eight months.

[d]Massachusetts' Buy-In program is the only one authorized through an 1115 Medicaid demonstration waiver. See Appendix A for more information.

## C. ENROLLMENT DYNAMICS

As Buy-In programs mature, states may begin to shift their focus from enrolling individuals to retaining eligible enrollees in their program. Therefore, understanding the factors contributing to enrollment growth and turnover becomes increasingly important. To examine enrollment dynamics, we first look at the growth of penetration rates between programs' first and second years of operation. We then analyze three measures of enrollment dynamics. First, we consider how new enrollment as a proportion of the total population ever enrolled in a given calendar year (hereafter, the ever-enrolled population) changes from one year to the next. Second, we analyze two indicators of program turnover—the proportion of the ever enrolled who remained in the program for the entire calendar year (hereafter, the continuously enrolled population) and the proportion with program experience who re-enrolled during the calendar year (called "churners").

### 1. Enrollment Growth

The results in Table IV.4 indicate that the rate at which enrollment grows differs markedly across states. In Minnesota, for example, the program grew the fastest in its second year (27 percent), partly because large numbers of individuals transferred into the Buy-In program from other Medicaid eligibility groups. Enrollment in Minnesota's program reached a plateau after its rapid initial growth. In Arkansas, on the other hand, the penetration rate decreased in the program's second and third year. As noted above, this was most likely due to the addition of an unearned income limit and the use of more stringent income verification requirements.

One factor that affected enrollment growth in a number of states was the level of outreach. For instance, Pennsylvania's program undertook "massive" amounts of outreach in its first two years. Similarly, state staff in California, Illinois, and Washington noted that greater outreach in the program's second year caused enrollment growth.

**Table IV.4. State-Level Change in Buy-In Enrollment per 100,000 State Residents Age 18 to 64**

| State | Implementation Date | Enrollment at Specific Times Since Program Inception | | | | | Percentage Change versus Previous Year | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | 1 Year | 2 Years | 3 Years | 4 Years | 5 Years | Year 2 vs. Year 1 | Year 3 vs. Year 2 | Year 4 vs. Year 3 | Year 5 vs. Year 4 |
| Massachusetts[a] | July 1997 | 54 | 76 | 93 | 118 | 142 | 39 | 23 | 26 | 21 |
| South Carolina | October 1998 | 1 | 2 | 3 | 3 | 2 | 105 | 56 | -23 | -24 |
| Oregon | February 1999 | 8 | 16 | 21 | 27 | 26 | 99 | 36 | 25 | -3 |
| Alaska | July 1999 | 14 | 27 | 35 | 43 | 48 | 91 | 30 | 23 | 12 |
| Minnesota | July 1999 | 164 | 208 | 193 | 203 | 191 | 27 | -7 | 5 | -6 |
| Nebraska[b] | July 1999 | 5 | 9 | 8 | 11 | 9 | 65 | -6 | 29 | -12 |
| Maine[b] | August 1999 | 42 | 75 | 91 | 62 | 74 | 78 | 21 | -31 | 18 |
| Vermont | January 2000 | 59 | 83 | 106 | 113 | 128 | 42 | 28 | 6 | 13 |
| Iowa | March 2000 | 111 | 187 | 273 | 343 | 418 | 68 | 46 | 25 | 22 |
| Wisconsin | March 2000 | 28 | 51 | 113 | 154 | 221 | 79 | 122 | 36 | 44 |
| California | April 2000 | 1 | 3 | 3 | 4 | - | 103 | 22 | 34 | - |
| Connecticut | October 2000 | 75 | 105 | 127 | 145 | - | 40 | 21 | 14 | - |
| New Mexico | January 2001 | 45 | 71 | 82 | 100 | - | 58 | 16 | 22 | - |
| Arkansas | February 2001 | 11 | 4 | 2 | 3 | - | -65 | -47 | 35 | - |
| New Jersey | February 2001[c] | 11 | 18 | 25 | - | - | 56 | 41 | - | - |
| Utah | July 2001 | 17 | 13 | 17 | - | - | -19 | 25 | - | - |
| Illinois | January 2002 | 4 | 7 | 8 | - | - | 63 | 23 | - | - |
| Pennsylvania | January 2002 | 17 | 32 | 63 | - | - | 96 | 96 | - | - |
| Washington | January 2002 | 4 | 6 | 11 | - | - | 62 | 86 | - | - |
| New Hampshire | February 2002 | 119 | 149 | 151 | - | - | 26 | 1 | - | - |
| Indiana | July 2002 | 119 | 147 | - | - | - | 23 | - | - | - |
| Kansas | July 2002 | 34 | 44 | - | - | - | 32 | - | - | - |
| Missouri | July 2002 | 364 | 489 | - | - | - | 34 | - | - | - |
| New York | July 2003 | 13 | - | - | - | - | - | - | - | - |
| Louisiana | January 2004 | 15 | - | - | - | - | - | - | - | - |
| Michigan | January 2004 | 2 | - | - | - | - | - | - | - | - |
| North Dakota | May 2004 | 64[d] | - | - | - | - | - | - | - | - |
| West Virginia | May 2004 | 8[d] | - | - | - | - | - | - | - | - |

**Table IV.4 (*continued*)**

Source: State data submitted to CMS in quarterly reports and the US Bureau of the Census (2005).

Note: Calculation of Buy-In Enrollment per 100,000 state residents age 18 to 64 is based on US Bureau of the Census estimates for July of a given year. Some measures could not be calculated for all programs. For example, it was not possible to calculate a program's enrollment per 100,000 state residents age 18 to 64 at three years since inception if the program was only two years old as of December 2004. We put a dash in the cells in this table when this was the case.

[a]Massachusetts' Buy-In program is the only one authorized through an 1115 Medicaid demonstration waiver. See Appendix A for more information.

[b]State personnel in Nebraska noted that their enrollment numbers in 2004 (that is, 5 years since inception) may be incorrect. Personnel in Maine noted that the Buy-In enrollment numbers for 2003 (that is, 4 years since inception) may be incorrect.

[c]New Jersey's official implementation date is February 2000, but the program began processing applications in February 2001, so we assume this is the program's start date.

[d]Programs began in May 2004; therefore, calculation of enrollment per 100,000 state residents age 18 to 64 is based on December 2004 enrollment.

In Missouri, which has the highest penetration rate of all states after the first year and thereafter, program personnel noted that vigorous outreach efforts by advocacy groups contributed greatly to the program's initial growth. Because of a delay in Missouri's appropriation of funds for the Buy-In program, about 18 months elapsed between the drafting of the state's Buy-In legislation and program implementation. State officials commented that the delay gave advocates ample time to "beat the bushes," spreading word about the program and encouraging individuals in the state's spend-down program to enroll in the Buy-In program. State officials in Minnesota also commented that the rapid enrollment growth in the program's first year was closely related to (1) effective outreach by advocacy groups and the disability community as a whole and (2) well-trained county eligibility workers whose thorough knowledge of the Buy-In program made them effective at enrolling persons with disabilities in the Buy-In program.

Other factors also affected early growth in program enrollment. In Wisconsin, for example, enrollment was slow at first because eligibility determination was processed manually. Automation of the process was a major reason for the 122 percent growth between the program's second and third years. Utah's decision to increase premiums in the program's second year is likely to be partially responsible for the state's 19 percent decrease in enrollment.

### 2. New Enrollment

As expected, new enrollment as a proportion of the ever enrolled decreased in 17 of the 22 states with data for both 2003 and 2004 (see Table IV.4). In growing programs with a constant stream of new enrollees, new enrollment will constitute a progressively smaller proportion of the ever enrolled in a given year. In fact, new enrollment as a proportion of the ever enrolled increased between 2003 and 2004 in only four states, and in two cases (California and Washington) state personnel believe that the growth was attributable to greater outreach in 2004.

### 3. Program Turnover

The first measure of program turnover that we analyze is the proportion of a program's ever enrolled population that remains continuously enrolled for the entire calendar year. This proportion ranges from 64 percent in Nebraska to 6 percent or below in states that began program operation in 2004 (Table IV.5). We also present information on the prevalence of reenrollment. A reenrollee is someone who enrolls in the program after having been enrolled at some time in the past. The proportion of the ever-enrolled population with program experience that re-enrolled during 2004 ranged from 34 percent in Utah to 0 percent in Michigan and West Virginia (Table IV.5). Not surprisingly, re-enrollment was 1 percent or less in three of the four programs that began operation in 2004 (Louisiana, Michigan, and West Virginia). North Dakota, which began its program in May 2004 and saw 33 percent of its ever enrolled population re-enroll in 2004, was exceptional in this regard.

Program features such as a grace period and a premium requirement can affect both continuous enrollment and reenrollment. As described earlier, a grace period can allow participants to remain enrolled in the program during spells of unemployment. It is therefore reasonable to expect that a program's provision of a grace period will be reflected in its level of continuous enrollment, as demonstrated by Table IV.5. Four of the five states with the highest proportion of continuously enrolled participants provide a grace period, whereas only two of the five states that had the lowest proportion of continuously enrolled participants and began operating before 2004 have one. In addition, individuals in states with a grace period may be less likely to reenroll because a grace period may prevent them from disenrolling in the first place. However, the data in Table IV.5 do not show a strong relationship between reenrollment and grace periods.

Another key factor that is likely to affect continuous enrollment and reenrollment is the proportion of the Buy-In population required to pay a premium. Participants required to pay a premium but who fail to do so on time may be required to disenroll and subsequently reenroll, potentially increasing the proportion of reenrollment and decreasing continuous enrollment. In Utah, for example, state personnel noted that the individuals who have difficulty paying the premium frequently cycle on and off the program. However, we did not find a compelling relationship across states between reenrollment and the proportion paying a premium.

## D. OTHER MEASURES OF BUY-IN ENROLLMENT

In addition to the enrollment measures presented above, we use two other measures of enrollment in subsequent sections of this report: the number of individuals who enrolled for the first time in a given year and the number of individuals who were enrolled for the entire fourth quarter of a given year. The first of these two groups allows us to describe characteristics of new Buy-In participants. The second allows us to analyze characteristics of participants who were enrolled for at least three months. For comparison, Table IV.6 includes the size of the two groups in calendar year 2004 and compares them to the enrollment count as of the end of 2004.

**Table IV.5. Enrollment Dynamics of Buy-In Participants, by State, 2003 and 2004**

| State | Number Ever Enrolled | | New Enrollment[a] (percent of ever enrolled) | | Continuously Enrolled[b] (percent of ever enrolled) | Re-Enrollment[c] (percent of ever enrolled) | | Grace Period (Months) | Percent Required to Pay a Premium, 2004 |
|---|---|---|---|---|---|---|---|---|---|
| | 2003 | 2004 | 2003 | 2004 | 2004 | 2004 | Rank | | |
| Nebraska | 151 | 134 | 29 | 48 | **64** | 7 | 16 | | 2 |
| South Carolina | 76 | 66 | N/R | 29 | **61** | 3 | 22 | | 0 |
| Iowa | 7,586 | 9,246 | 30 | 28 | **60** | 6 | 19 | Yes (6) | 25 |
| Minnesota | 8,490 | 8,094 | 22 | 17 | **57** | 11 | 9 | Yes (4) | 100 |
| Kansas | 830 | 1,001 | 43 | 33 | **53** | 3 | 21 | Yes (6) | 60 |
| Oregon | 981 | 782 | 34 | 20 | **52** | 8 | 14 | Yes[d] | 51 |
| Wisconsin | 6,767 | 9,146 | 41 | 35 | **51** | 7 | 15 | Yes(6) | 10 |
| Missouri | 17,630 | 22,784 | 50 | 33 | **51** | 1 | 25 | | 16 |
| New Jersey | 1,161 | 1,626 | 47 | 42 | **50** | 4 | 20 | Yes (6.5) | 0 |
| Indiana | 7,887 | 8,862 | 47 | 35 | **44** | 7 | 17 | Yes (12) | 28 |
| California | 1,152 | 1,502 | 41 | 45 | **42** | 9 | 13 | | 100 |
| Connecticut | 3,838 | 4,318 | 33 | 29 | **42** | 16 | 6 | Yes (12) | 12 |
| New Hampshire | 1,510 | 1,915 | 34 | 32 | **37** | 12 | 8 | Yes (12) | 32 |
| Washington | 288 | 545 | 42 | 47 | **33** | 6 | 18 | Yes(12) | 100 |
| New Mexico | 1,520 | 1,797 | 48 | 49 | **32** | 2 | 24 | | 0 |
| Massachusetts[e] | 10,949 | 10,858 | 31 | 29 | **32** | 23 | 3 | Yes (3) | 91 |
| Maine | 1,166 | 1,027 | 37 | 34 | **31** | 15 | 7 | | 6 |
| Illinois | 712 | 905 | 54 | 30 | **30** | 10 | 10 | Yes (3) | 99 |
| Arkansas | N/R | 113 | N/R | 15 | **29** | 2 | 23 | Yes (6) | 0 |
| Vermont | 760 | 840 | 35 | 34 | **28** | 21 | 4 | | 0 |
| Alaska | 307 | 347 | 42 | 39 | **27** | 10 | 11 | | 65 |
| New York | 672 | 3,494 | 100 | 61 | **26** | 19 | 5 | Yes (6) | 0 |
| Pennsylvania | 3,148 | 5,463 | 58 | 19 | **25** | 9 | 12 | Yes(2) | 94 |
| Utah | 433 | 496 | 53 | 53 | **15** | 34 | 1 | | 88 |
| Louisiana | N/A | 522 | N/A | 100 | **6** | 1 | 26 | Yes (6) | 9 |
| North Dakota | N/A | 277 | N/A | 100 | **0** | 33 | 2 | Yes[f] | 100 |
| Michigan | N/A | 125 | N/A | 100 | **0** | 0 | 27 | Yes (24) | 0 |
| West Virginia | N/A | 86 | N/A | 100 | **0** | 0 | 27 | Yes(6) | 94 |
| Total | 78,069 | 96,408 | 40 | 32 | **45** | 9 | | | 38 |

**Table IV.5 (*continued*)**

Source: 2003 and 2004 Annual Buy-In Reports. Number ever enrolled is based on individual-level data provided by each state except for states in their first year of operation (i.e., Louisiana, Michigan, New York (2003 only), North Dakota, and West Virginia). In these cases, we used the cumulative enrollment (i.e., the number of participants ever enrolled since the program's inception).

Note: Information above is sorted in descending order of the proportion continuously enrolled in 2004.

[a]Calculated as the number of new enrollees in 2004 divided by the number ever enrolled in a given year. New enrollees are individuals who have not participated in the Buy-In program since it began or since January 2000, whichever is more recent.

[b]Calculated as the number of Buy-In participants enrolled for all of calendar year 2004 divided by the number ever enrolled in a given year.

[c]Calculated as the number of individuals who reenrolled in the Buy-In program divided by the number ever enrolled in a given year. "Reenrollees" are individuals who had (a) a previous enrollment in the Buy-In program at any time since the program began or January 2000, whichever is more recent; (b) disenrolled from the program; and (c) enrolled again in calendar year 2004.

[d]Unemployed Buy-In participants in Oregon may remain in the program if they retain an employment relationship with their employer or would otherwise be eligible for another Medicaid eligibility category.

[e]Massachusetts' Buy-In program is the only one authorized through an 1115 Medicaid demonstration waiver. See Appendix A for more information.

[f]Participants may remain in the program if they experience a job loss due to health problems.

N/A = Not applicable. Buy-In programs in Louisiana, Michigan, North Dakota, and West Virginia did not begin until 2004.

N/R = Not reported. Arkansas and South Carolina had Buy-In programs in 2002 and 2003 but did not have a MIG and thus did not submit data.

**Table IV.6. Number of Participants Enrolled in Medicaid Buy-In Programs in 28 States, Calendar Year 2004**

| State | First-Time Participants | Fourth-Quarter Participants | End-of-Year Enrollment |
|---|---|---|---|
| Alaska | 134 | 173 | 194 |
| Arkansas | 17 | 45 | 48 |
| California | 681 | 1,085 | 1,165 |
| Connecticut | 1,265 | 2,940 | 3,365 |
| Illinois | 274 | 558 | 656 |
| Indiana | 3,129 | 5,899 | 6,117 |
| Iowa | 2,559 | 7,540 | 7,695 |
| Kansas | 331 | 782 | 823 |
| Louisiana | 522 | 385 | 424 |
| Maine | 353 | 591 | 644 |
| Massachusetts | 3,098 | 6,521 | 7,520 |
| Michigan | 125 | 84 | 140 |
| Minnesota | 1,376 | 5,731 | 6,165 |
| Missouri | 7,446 | 17,126 | 18,610 |
| Nebraska | 64 | 125 | 67[a] |
| New Hampshire | 616 | 1,027 | 1,268 |
| New Jersey | 678 | 1,276 | 1,351 |
| New Mexico | 876 | 1,155 | 1,181 |
| New York | 2,141 | 2,597 | 2,480 |
| North Dakota | 277 | 207 | 258 |
| Oregon | 160 | 543 | 583 |
| Pennsylvania | 1,026 | 3,721 | 4,865 |
| South Carolina | 19 | 50 | 52 |
| Utah | 263 | 168 | 260 |
| Vermont | 285 | 443 | 520 |
| Washington | 258 | 369 | 448 |
| West Virginia | 86 | 49 | 90 |
| Wisconsin | 3,228 | 7,092 | 7,713 |
| Total | 31,287 | 68,282 | 74,702 |

Sources: State Annual Buy-In Reports for 2004 and state quarterly reports submitted to CMS.

Note: First-time participants are individuals who enrolled in the Buy-In program for the first-time in calendar year 2004. Fourth-quarter participants are individuals who were enrolled in the Buy-In program for the entire fourth quarter of the 2004 calendar year. End-of-year enrollment provides a count of participants enrolled in the Buy-In program as of December 31, 2004.

[a]State personnel in Nebraska noted that their end-of-year enrollment data may be inaccurate.

# CHAPTER V

# WHO PARTICIPATES IN THE MEDICAID BUY-IN PROGRAM?

Understanding the characteristics of Buy-In participants is important for determining the program's success in reaching its intended audience and assessing its fiscal implications. For example, programs that are designed to attract individuals new to Medicaid may have a different financial impact on overall Medicaid expenditures than a program that encourages current Medicaid beneficiaries to move from one eligibility group (such as the medically needy program) to the Buy-In program.

Participation in other benefit and health insurance programs also has important implications for participants' need for the Buy-In program and its effectiveness as a work incentive. For example, SSDI recipients are automatically eligible for Medicare coverage after a two-year waiting period. If not already enrolled in Medicaid, these individuals might need the Buy-In program during the waiting period. Furthermore, the SSDI "cash cliff" creates a work disincentive (Hoynes and Moffitt 1999). SSDI recipients may lose their cash benefits and, eventually, Medicare coverage if their earnings exceed the substantial gainful activity (SGA) level ($810 per month in 2004) for an extended period.[1] As a result, many SSDI beneficiaries enrolled in the Buy-In program may want to maintain their enrollment in order to continue their Medicaid coverage but do not want to work so much that they threaten continuation of their SSDI benefits. However, the strength of this disincentive depends on the amount of potential income that the SSDI recipient believes he or she could earn. For example, if the recipient could earn $3,300 per month, the loss of a monthly SSDI cash benefit of, say, $800 would be much less of a work disincentive than for a person who anticipates earning $1,200 per month.

Other factors, such as the program's operational features and the state policy context in which the program operates, also influence the characteristics of Buy-In participants. For

[1] An SSDI beneficiary becomes eligible for Medicare after a two-year waiting period. Once on SSDI, a recipient may test his or her ability to work during a trial work period (TWP). During this period, an SSDI beneficiary may work and receive full SSDI benefits for nine (not necessarily consecutive) months in a rolling 60-consecutive-month period. Once the TWP has ended, Medicare coverage typically continues for people with disabilities for at least 93 months. See http://www.socialsecurity.gov/redbook/ for more detail.

example, the likelihood that a Buy-In participant has Medicaid experience before Buy-In enrollment is closely related to the eligibility criteria used by a state for traditional Medicaid coverage. In addition, policies governing the treatment of unearned income are directly related to the pool of individuals potentially eligible for the Buy-In program.

## A. PREVIOUS ENROLLMENT IN MEDICAID

The Buy-In program provides individuals with one of many ways to qualify for Medicaid coverage, and understanding participants' Medicaid enrollment before entering the Buy-In program provides insight into how and why individuals move into the Buy-In program. This section describes the national trend in Medicaid coverage before enrollment in the Buy-In program, discusses state variations in that trend, and, finally, describes the Medicaid eligibility groups for which individuals qualify before enrolling in the Buy-In program.

### 1. National Trends

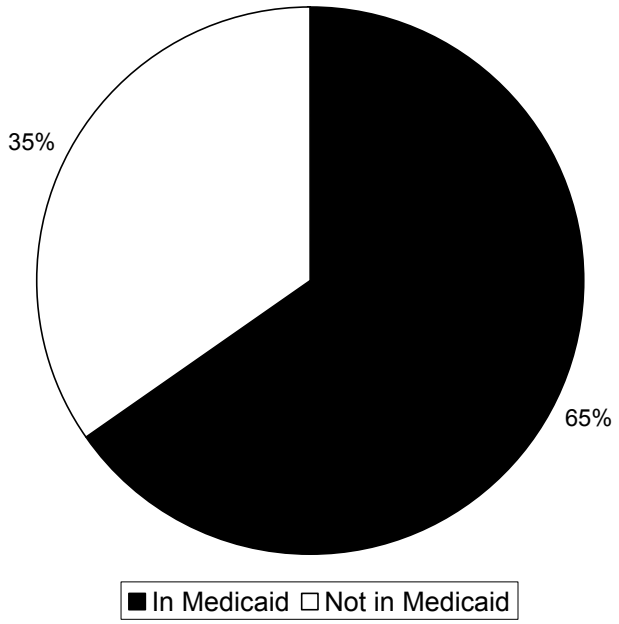
About two-thirds (65 percent) of new Buy-In participants in 2004 were enrolled in Medicaid before enrolling in the Buy-In program (see Figure V.1). For the 20 states with data in both 2003 and 2004, the proportion decreased from 73 percent in 2003 to 63 in 2004. As described in more detail below, one potential explanation for the reduction is the program's maturity. In the initial years of Buy-In program operation, persons with disabilities in other Medicaid eligibility groups could transfer into the Buy-In program. Transfers may be less likely as the pool of individuals who can potentially transfer from other Medicaid eligibility groups into the Buy-In program becomes smaller.

### 2. State Trends

The results in Figure V.2 demonstrate that the proportion of new Buy-In participants in 2004 who were previously in Medicaid varies substantially across states, from 30 percent in Missouri in 2004 to 100 percent in Michigan. Differences across states appear to be related to the eligibility criteria for traditional Medicaid groups. For 2004, the five states with the lowest proportion of Buy-In enrollees who were previously enrolled in Medicaid (that is, Missouri, West Virginia, Arkansas, Louisiana, and North Dakota) all have relatively restrictive eligibility criteria for other Medicaid groups. None of these five states provides "poverty-level" Medicaid to people with disabilities, and three of the five (Arkansas, Louisiana, and West Virginia) have an income threshold of $200 or below for their Medically Needy programs. Similarly, all but two (Connecticut and Vermont) of the eight states with the highest proportion of Buy-In participants with previous Medicaid coverage have a poverty-level Medicaid group. In Michigan, all Buy-In participants were enrolled in another Medicaid eligibility group before Buy-In enrollment because enrollment in Medicaid is an eligibility requirement designed to ensure that the program is budget-neutral. [2]

[2] This state-imposed requirement is contrary to the BBA and Ticket statutes and CMS regulations.

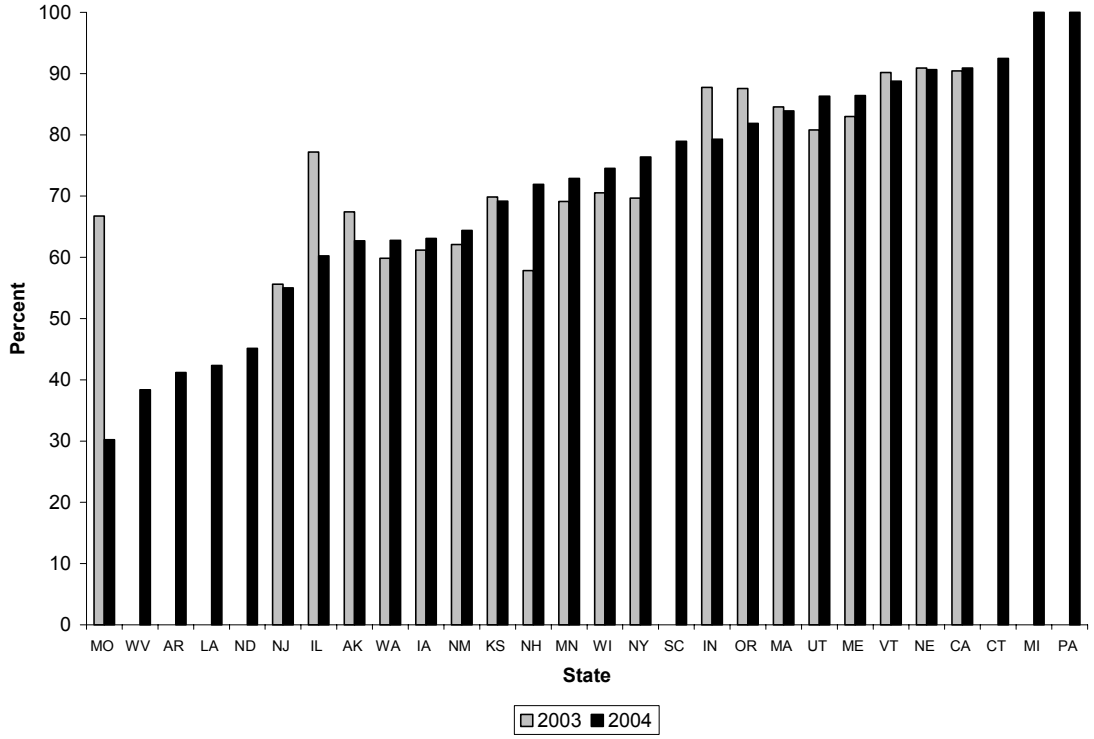
**Figure V.I. Medicaid Eligibility Status for New Participants before Enrollment in the Medicaid Buy-In Program, 28 States, Calendar Year 2004**




Source: State Annual Buy-In Reports for 2004.

Note: The data are based on individuals who enrolled in the Buy-In program for the first time in 2004. Participants are considered to have been enrolled in Medicaid before enrolling in the Buy-In program if they were in Medicaid for at least 30 consecutive days in the 12 months before Buy-In enrollment.

**Figure V.2. Percent of Participants in Medicaid Before Enrollment in the Buy-In Program, Calendar Years 2003 and 2004**




Source: State Annual Buy-In Reports for 2003 and 2004.

Note: The data refer to individuals who enrolled in the Buy-In program for the first time in a given year and are sorted in ascending order of their percent with previous Medicaid enrollment in 2004. Connecticut and Pennsylvania did not submit data in 2003. Programs in Louisiana, Michigan, North Dakota, and West Virginia did not begin until 2004. Arkansas and South Carolina had a program in 2003 but did not have a MIG at the time and did not submit data. Personnel in Pennsylvania noted that their 2004 data may be inaccurate. Information from a new data system that New York began using in 2005 suggests that the system from which the information above was drawn may have undercounted the number of Buy-In participants enrolled in the Medicaid poverty-related category prior to Buy-In enrollment (see note to Table V.1 for a definition of the poverty-related category). This suggests that the proportion above for New York may be an underestimate of the true proportion.

Several factors, including the maturation of a state's program, may affect how the proportion of participants with previous Medicaid experience changes from one year to the next. In three states with programs that began in 2002—Missouri, Illinois, and Indiana—the proportion decreased between 2003 and 2004. State personnel in Indiana and Missouri noted that the proportion was high early in the program because Medicaid enrollees for whom the Buy-In was an option transferred into the program. That new Buy-In participants were more likely to enroll directly in the program rather than first entering another Medicaid eligibility category (for example, the medically needy program) might explain the decreasing proportion of transfers over time. This process may have contributed to the declining proportion between 2003 and 2004 of individuals transferring from Missouri's spend down program.[3] In addition, state personnel in Illinois noted that their proportion of Buy-In participants with previous Medicaid experience decreased from 77 percent in 2003 to 60 percent in 2004 because, early on, they limited outreach primarily to Medicaid enrollees and, in 2004, targeted outreach to other groups. Finally, personnel in New Hampshire noted that automation of the state's Medicaid eligibility system in 2004 likely explains the greater proportion of participants with prior Medicaid experience in that year. With automation, eligibility workers could more easily identify potential Buy-In participants among all Medicaid enrollees.

### 3. Medicaid Eligibility Groups

Table V.1 shows the distribution of Medicaid eligibility groups in which individuals were enrolled before entering the Buy-In program: cash assistance (SSI, a state supplement, or the Section 1619(a) provision), the medically needy group (including the spend-down group for Section 209(b) states), the poverty-level group, and all other Medicaid eligibility groups (including the Section 1619(b) provision).

The cash assistance group in Table V.1 includes Buy-In participants who either had been receiving SSI cash benefits before Buy-In enrollment (including state supplementary payments) or had been eligible under Section 1931 of the Social Security Act.[4] In 20 of the 28 states, fewer than 30 percent of new Buy-In participants in 2004 received cash assistance immediately before Buy-In enrollment. In 9 states, 10 percent or fewer received cash assistance. In part, these findings reflect how the cash assistance group is defined. The group does not include individuals who received Medicaid through the Section 1619(b) provision, which covers SSI beneficiaries whose income increases above the income threshold for SSI cash benefits.

[3] Missouri is a Section 209(b) state and has a spend down, rather than a medically needy, program. These two programs are operationally similar. See Chapter II for additional information about Section 209(b) states and spend down programs.

[4] See Table V.1 for detail about Section 1931 of the Act.

**Table V.1. Percent of New Participants in Medicaid Eligibility Groups Before Enrollment in the Medicaid Buy-In Program, by State, 2003–2004**

| State | Total Participants with Medicaid Eligibility Before Buy-In Enrollment | | Percent of Participants with Medicaid Before Enrollment | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | Cash Assistance[a] | | Medically Needy[b] | | Poverty Related[c] | | Other[d] | |
| | 2003 | 2004 | 2003 | 2004 | 2003 | 2004 | 2003 | 2004 | 2003 | 2004 |
| Alaska[e] | 87 | 84 | 97 | 93 | 0 | 0 | 0 | 4 | 3 | 4 |
| Arkansas[f] | N/R | 7 | N/R | 0 | N/R | 0 | N/R | 0 | N/R | 100 |
| California | 426 | 619 | 6 | 11 | 48 | 35 | 25 | 21 | 21 | 33 |
| Connecticut[f] | N/R | 1,170 | N/R | 10 | N/R | 47 | N/R | 33 | N/R | 9 |
| Illinois | 294 | 165 | 0 | 1 | 66 | 91 | 34 | 8 | 0 | 0 |
| Indiana[g] | 3,248 | 2,481 | 1 | 14 | 0 | 6 | 99 | 80 | 0 | 0 |
| Iowa[f] | 1,369 | 1,614 | 31 | 37 | 27 | 23 | 26 | 25 | 16 | 15 |
| Kansas[f] | 248 | 229 | 21 | 14 | 46 | 22 | 20 | 53 | 14 | 10 |
| Louisiana[f] | N/A | 221 | N/A | 33 | N/A | 14 | N/A | 33 | N/A | 21 |
| Maine | 361 | 305 | 26 | 15 | 1 | 0 | 60 | 69 | 14 | 15 |
| Massachusetts[e] | 2,832 | 2,599 | 1 | 1 | 0 | 0 | 32 | 27 | 67 | 72 |
| Michigan | N/A | 125 | N/A | 91 | N/A | 0 | N/A | 9 | N/A | 0 |
| Minnesota | 1,287 | 1,003 | 19 | 18 | 33 | 31 | 14 | 27 | 34 | 25 |
| Missouri[f] | 5,862 | 2,249 | 14 | 26 | 55 | 24 | 5 | 7 | 25 | 42 |
| Nebraska | 40 | 58 | 28 | 24 | 3 | 3 | 70 | 72 | 0 | 0 |
| New Hampshire[f] | 295 | 443 | 54 | 53 | 40 | 37 | 6 | 10 | 0 | 0 |
| New Jersey | 302 | 373 | 22 | 33 | 0 | 0 | 52 | 44 | 26 | 23 |
| New Mexico[e,f] | 454 | 564 | 92 | 88 | 0 | 0 | 5 | 9 | 4 | 4 |
| New York[f] | 468 | 1,635 | 4 | 15 | 91 | 82 | 0 | 0 | 5 | 3 |
| North Dakota[f] | N/A | 125 | N/A | 8 | N/A | 88 | N/A | 4 | N/A | 0 |
| Oregon[h] | 296 | 131 | 1 | 2 | 42 | 0 | 22[j] | 89[j] | 35 | 9 |
| Pennsylvania[i] | N/R | 1,378 | N/R | 47 | N/R | 15 | N/R | 38 | 0 | 1 |
| South Carolina[e] | N/R | 15 | N/R | 27 | N/R | 0 | N/R | 73 | N/R | 0 |

Table V.1 (*continued*)

| State | Total Participants with Medicaid Eligibility Before Buy-In Enrollment | | Percent of Participants with Medicaid Before Enrollment | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | Cash Assistance[a] | | Medically Needy[b] | | Poverty Related[c] | | Other[d] | |
| | 2003 | 2004 | 2003 | 2004 | 2003 | 2004 | 2003 | 2004 | 2003 | 2004 |
| Utah | 185 | 227 | 4 | 8 | 89 | 80 | 7 | 11 | 1 | 1 |
| Vermont | 239 | 253 | 10 | 8 | 63 | 66 | 0 | 0 | 27 | 26 |
| Washington[f] | 73 | 162 | 14 | 10 | 42 | 48 | 12 | 14 | 32 | 28 |
| West Virginia[f] | N/A | 33 | N/A | 27 | N/A | 67 | N/A | 0 | N/A | 6 |
| Wisconsin[f] | 1,946 | 2,406 | 20 | 17 | 27 | 28 | 8 | 8 | 45 | 48 |
| Total | 20,312 | 20,674 | 14 | 22 | 30 | 26 | 29 | 27 | 27 | 25 |

Source: State Annual Buy-In Reports for 2003 and 2004.

Note: The data refer to those individuals who enrolled in the Buy-In program for the first time in a given year. Column headings correspond to the Medicaid Assistance Status (MAS) categories as described in the Medicaid Statistical Information System (MSIS). See Appendix B for definitions of these Medicaid eligibility groups. State personnel in Pennsylvania expressed concern about the accuracy of their data. Information from a new data system that New York began using in 2005 suggests that the system from which the information above was drawn may have undercounted the proportion of Buy-In participants enrolled in the Medicaid poverty-related category prior to Buy-In enrollment.

[a]**The cash assistance group** includes individuals receiving SSI cash benefits, including state supplementary payments, for at least 30 consecutive days during the year before Buy-In enrollment or individuals who had been eligible under Section 1931 of the Social Security Act. Section 1931 of the Act requires states to extend Medicaid coverage to parents and children who would have been eligible for Medicaid through the Aid to Families and Dependent Children (AFDC) 1996 income thresholds. This group does not include individuals receiving Medicaid through the SSI Section 1619(b) provision because such individuals do not receive SSI cash benefits.

[b]**The medically needy group** includes individuals in a state's medically needy or spend-down program for at least 30 consecutive days during the year before Buy-In enrollment.

[c]**The poverty-related group** includes individuals in the following Medicaid eligibility groups for at least 30 consecutive days during the year before Buy-In enrollment: poverty-level Medicaid and individuals whose Medicare cost-sharing requirements are fully or partly paid by Medicaid (that is, Qualified Medicare Beneficiaries (QMBs), Specified Low-Income Medicare Beneficiaries (SLMBs), Qualifying Individuals (QIs), and Qualified Disabled and Working Individuals (QDWIs).

[d]**The other group** includes individuals in the following Medicaid eligibility groups for at least 30 consecutive days during the year before Buy-In enrollment: (1) 1115 demonstration waivers; (2) the Section 1619(b) provision for SSI beneficiaries; (3) disabled adult children with no SSI; and (4) widows and widowers with disabilities who do not have SSI.

[e]State does not have a medically needy or spend-down program.

[f]State does not have a poverty-level Medicaid eligibility group for people with disabilities.

[g]Indiana reported individuals in its spend-down program before Buy-In enrollment as members of the poverty-related group in 2003. In 2004, however, individuals who had to spend down were classified in the medically needy group above, and individuals whose income was already below the income threshold of $564 for the spend-down program were classified in the poverty-related group.

[h]Oregon eliminated its medically needy program in February 2003.

[i]The total number of individuals in Pennsylvania with previous Medicaid enrollment (1,378) exceeds the size of the state's first-time group (1,026) because the state Medicaid enrollees who changed eligibility groups during the year are double counted, once for each eligibility group.

[j]Oregon does not have a poverty-level option but does provide Medicaid to individuals not receiving SSI but with countable income below the combined federal and state SSI benefit of $565.70 in 2004, and the state included these individuals in its poverty-related category.



N/A = Not applicable. Buy-In programs in Louisiana, Michigan, North Dakota, and West Virginia did not begin until 2004.

N/R = Not reported. Arkansas and South Carolina had Buy-In programs in 2002 and 2003 but did not have a MIG and thus did not submit data.

In some states, however, substantial proportions of new Buy-In participants were in the Medicaid cash assistance group (Table V.1). The magnitude of the proportion is surprising given the availability of the Section 1619(b) provision, suggesting that Medicaid eligibility based on that provision may be underused. This is an important issue for two reasons. First, people in mandatory coverage groups (for example, Medicaid coverage through receipt of SSI benefits) are not eligible for coverage in optional Medicaid eligibility groups like the Buy-In program. And second, if an individual is eligible for Medicaid through both the Section 1619(b) provision and the Buy-In program, the state is required to enroll the person in the former, which "does the least harm" by providing Medicaid without a premium requirement (CMS 2005b). Whether the 1619(b) provision is being underutilized is an important topic for future research.

One factor that could affect the use of the Section 1619(b) provision is the administrative connection between the SSI and Medicaid programs. In the seven Section 209(b) states, the eligibility criteria for SSI and Medicaid differ, but five other states require a separate application for Medicaid despite identical eligibility criteria for both SSI and Medicaid.[5] The separate applications for SSI and Medicaid make coordination between the two programs more difficult in these 12 states. In New Hampshire, which is a Section 209(b) state, 53 percent of participants in 2004 with previous Medicaid enrollment fell into the cash assistance category (see Table V.1), perhaps owing to the automation of the eligibility determination process. Before automation, eligibility workers had to depend on the applicant to provide information on SSI eligibility for Medicaid under Section 1619. As a result, some Buy-In participants may have been eligible for Medicaid through the Section 1619 provisions. However, beginning in 2005, eligibility workers in New Hampshire can obtain information on Section 1619(a) or 1619(b) eligibility electronically, potentially leading to greater reliance on those provisions.

Medically needy programs allow individuals to obtain Medicaid coverage if they do not qualify for mandatory groups. Individuals are generally eligible for medically needy programs if their income is below a state-specific threshold. If their income is higher than the threshold, they can qualify if the deduction of medical expenses brings their income below that threshold. Table V.1 demonstrates that, in some states, a high proportion of participants already enrolled in Medicaid before enrolling in Buy-In fell into the medically needy program. On the other hand, in 12 states, at most 14 percent of new Buy-In participants in 2004 with Medicaid experience came from medically needy programs. In 5 of these 12 states, the proportion was low because the state did not offer medically needy coverage. Moreover, the income threshold for 6 of the remaining 7 states is at most $400, which is relatively low and thus makes it difficult to establish eligibility through the medically needy group.

[5] The Section 209(b) states in this study are Connecticut, Illinois, Indiana, Minnesota, Missouri, New Hampshire, and North Dakota. The five states with the same eligibility criteria but separate applications for SSI and Medicaid are Alaska, Kansas, Nebraska, Oregon, and Utah.

States can extend Medicaid coverage to the aged, blind, and disabled with income less than 100 percent of the poverty level ($776 per month in 2004) and assets less than state-specified limits. Eleven of the 28 states with Buy-In programs have adopted this "poverty-level" group.[6] In addition, 1 state (Massachusetts) covers people with disabilities up to 133 percent of the FPL through a Section 1115 demonstration waiver. In Table V.1, the poverty-related category includes this "poverty-level" group in addition to individuals whose Medicare cost-sharing requirements are fully or partly paid by Medicaid (that is, Qualified Medicare Beneficiaries (QMBs), Specified Low-Income Medicare Beneficiaries (SLMBs), Qualifying Individuals (QIs), and Qualified Disabled and Working Individuals (QDWIs)).[7]

Among the other mandatory and optional ways to qualify for Medicaid coverage are through Section 1115 demonstration waivers, the Section 1619(b) work incentives provision, disabled adult children (DAC) with no SSI, and widows and widowers with disabilities who do not have SSI.[8] Massachusetts is the only state in which most of its participants with previous Medicaid coverage transfer to the Buy-In program from a Section 1115 demonstration waiver program. MassHealth, the Medicaid program in Massachusetts, is authorized under the waiver and covers all individuals with disabilities regardless of income and assets. In Massachusetts, about 7 in 10 (72 percent) of new participants in 2004 entered the Buy-In program through the "other" group, which consists almost entirely of the Section 1115 waiver program in this state.

## B. PARTICIPATION IN OTHER BENEFIT AND HEALTH INSURANCE PROGRAMS

Our findings show that most Buy-In participants receive SSDI cash benefits and have other health coverage such as Medicare and other private coverage. This section first examines nationwide participation in other benefit and health insurance programs and then describes state variation.

### 1. National Trends

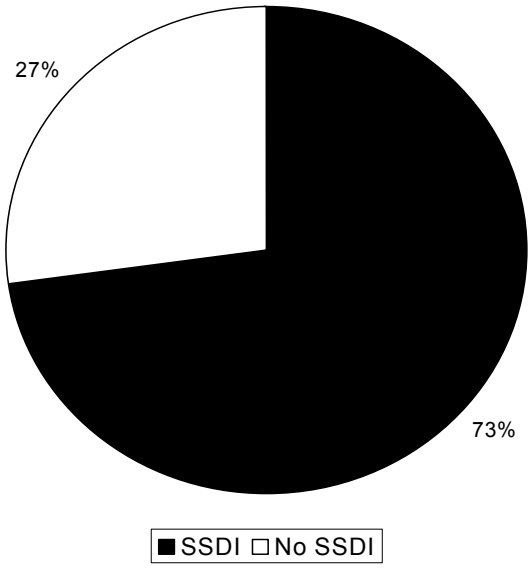
Results in Figure V.3 demonstrate that approximately three-fourths (73 percent) of Buy-In participants were SSDI recipients when they enrolled in the Buy-In program. The prevalence of SSDI recipients in the Buy-In program is not surprising given that recipients have already met the Social Security definition of disability and have work experience; the latter is an SSDI eligibility requirement. In addition, only about 2 in 10 (18 percent) Buy-In

[6] See Appendix A for more detail on which states offer the Medicaid poverty-level option.

[7] See Chapter II for more detail.

[8] A child with disabilities who receives a dependent's or survivor's benefit from Social Security may, if single, continue to receive benefits even into his or her adult years. If a disabled adult child (DAC) loses SSI eligibility due to increased income and is at least 18 years old, he or she is entitled to retain Medicaid coverage. Elderly disabled widows and widowers who do not qualify for SSI are eligible to receive full Medicaid benefits if they meet the SSI standard but for an increase in SSDI benefits.

**Figure V.3. SSDI Status of New Participants Before Enrollment in the Medicaid Buy-In Program, 26 States, 2004**




Source: State Annual Buy-In Reports for 2004.

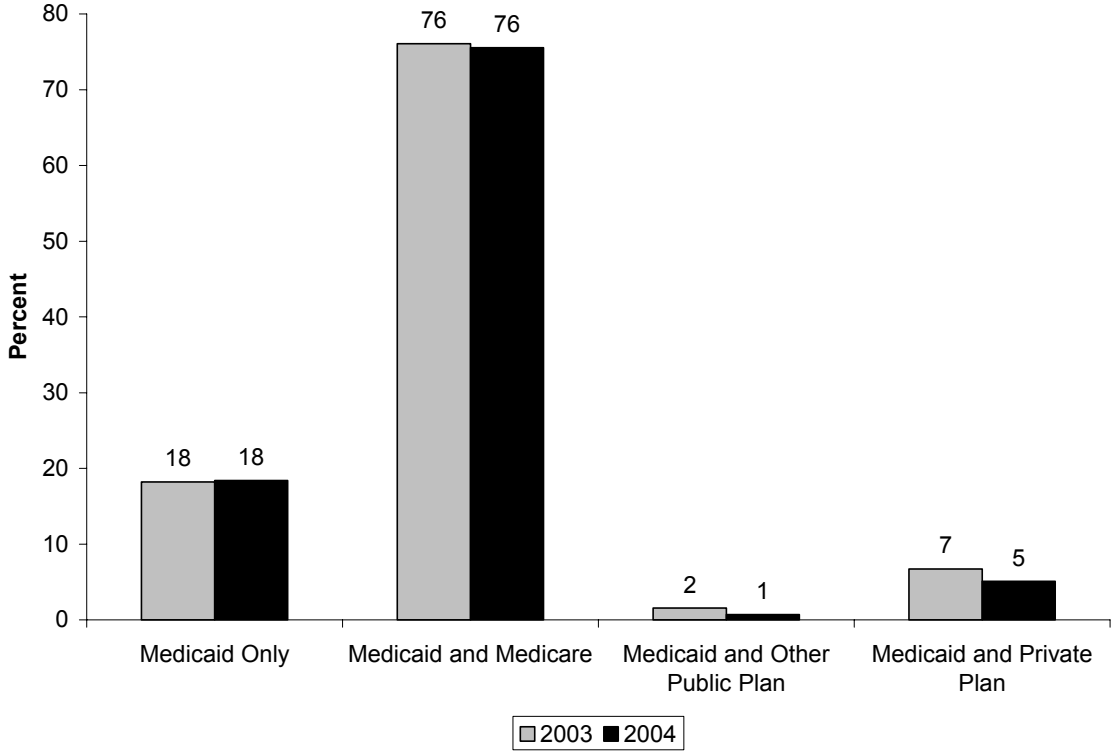
Note: The figure is based on new Buy-In participants in 2004 for whom SSDI status could be determined (the SSDI status of fewer than 0.5 percent of participants in the 26 states could not be determined). Data for Indiana were excluded because the state could not determine SSDI for beneficiaries not enrolled in Medicaid immediately before Buy-In enrollment. Data for Wisconsin were excluded because the state was unable to determine SSDI status for approximately one-third of its new participants.

participants are enrolled in Medicaid as their only source of health coverage (see Figure V.4). Medicare is by far the most common form of additional coverage—about three-fourths (76 percent) of Buy-In participants carry it, which is similar to the proportion of new participants in 2003 and 2004 who were on SSDI. This similarity is not surprising given that SSDI recipients automatically receive Medicare after a two-year waiting period. Fewer than 1 in 10 participants carry private coverage. In fact, when we look at the 20 states with these data in all three years, the proportion remained stable at 8 to 9 percent in 2002 and 2003 but decreased to 5 percent in 2004 (results not shown).

## 2. State Trends

Underlying the national trend in SSDI participation rates and additional forms of health insurance coverage is considerable state variation. In this section, we present state information on participation in SSDI and other programs and offer possible explanations for what may be driving differences across states.

**Figure V.4. Types of Health Insurance in Addition to Medicaid for Buy-In Participants, Calendar Years 2003 (22 States) and 2004 (25 States)**




Source: State Annual Buy-In Reports for 2003 and 2004.

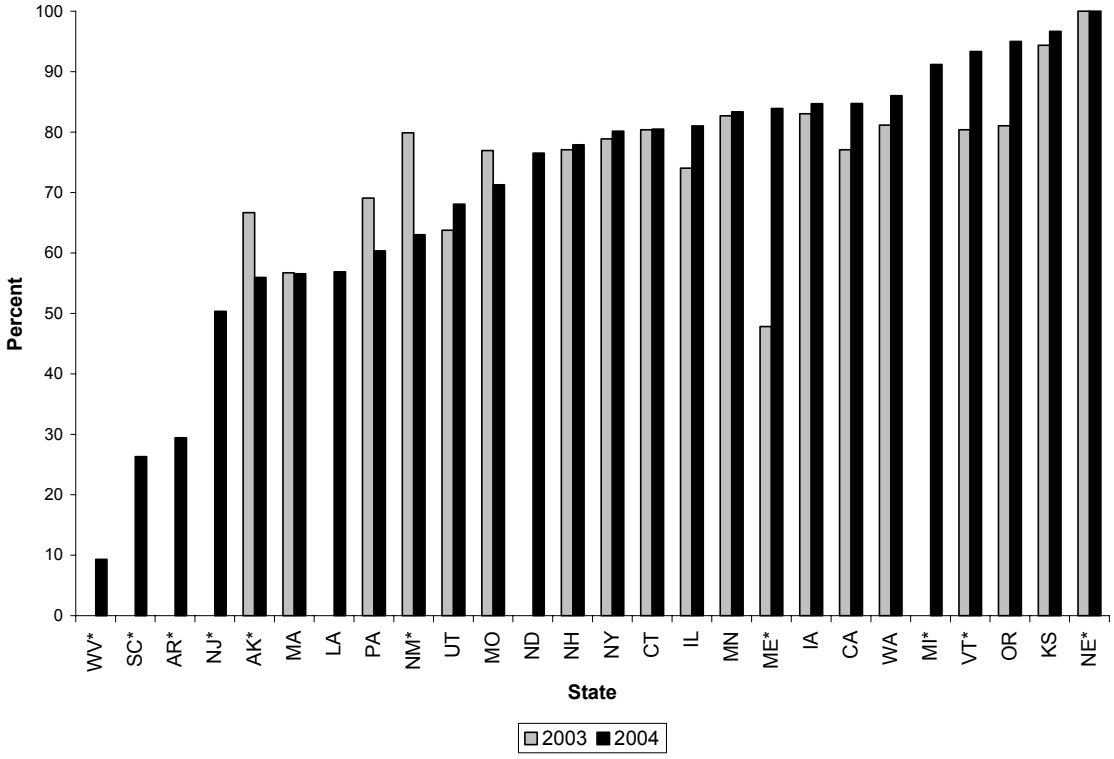
Note: The data refer to individuals enrolled for the entire fourth quarter of a given calendar year. Percentages for a given year may not sum to 100 because the categories are not mutually exclusive. Arkansas, Maine, and North Dakota did not submit data for 2004. Personnel in Maine and Wisconsin expressed concerns about the accuracy of their data on private coverage, and Alaska (in 2003) and New Jersey (in 2004) personnel cited difficulties in identifying Medicare coverage.

### a. SSDI and Medicare

The proportion of new Buy-In participants in 2004 receiving SSDI benefits ranged from a low of 9 percent in West Virginia to a high of 100 percent in Nebraska (see Figure V.5). An unearned income limit restricts the pool of SSDI beneficiaries who could potentially enroll in the Buy-In program. In addition, we observed a weak relationship between an unearned income limit and the proportion of new Buy-In participants receiving SSDI benefits. All five states that rank lowest on the SSDI measure have an unearned income limit as compared with three among the top five states. Nebraska is one notable exception in which all new Buy-In participants received SSDI benefits when they enrolled despite the state's unearned income limit of $564 per month in 2004. The income eligibility criteria for

Nebraska's program make it difficult for anyone other than SSDI recipients in their trial work period to enroll.[9]

**Figure V.5. Percent of Buy-In Participants Receiving SSDI Benefits at Enrollment, by State, Calendar Years 2003 and 2004**




Source: State Annual Buy-In Reports for 2003 and 2004.

Note: The figure is based on new Buy-In participants in 2004 for whom SSDI status could be determined (the SSDI status of fewer than 0.5 percent of participants in the 26 states could not be determined). Data for Indiana were excluded because the state could not determine SSDI for enrollees who were not enrolled in Medicaid immediately before Buy-In enrollment. Data for Wisconsin were excluded because the state was unable to determine SSDI status for approximately one-third of its new participants. States are sorted in ascending order according to their proportion in 2004.

*Program has an unearned income limit.

[9] Nebraska's Buy-In program has a two-part income test. First, countable income, which is the sum of the applicant's unearned income and spousal earned income, must be less than the SSI standard (that is, $564 in 2004). Second, countable family income (including unearned income) must be below 250 percent of the FPL. See Appendix A for more information about Nebraska's program.

Given that SSDI recipients are automatically eligible for Medicare after a two-year waiting period, it is reasonable to expect similarities in the proportion of Buy-In participants on SSDI and the proportion of Medicare enrollees. We compared the two proportions as part of our data verification process. Figure V.6 presents the proportion on SSDI minus the proportion on Medicare in 2004 and shows that, in all but four states, the differences are within 10 percentage points. Several reasons might explain the minor variation. First and foremost, the proportions are based on different samples—the proportion receiving SSDI is based on new Buy-In participants, and the proportion on Medicare is based on those enrolled in fourth-quarter 2004. Second, a participant could receive SSDI and not Medicare if he or she is in the two-year waiting period. New Mexico's reliance on its eligibility criteria to target SSDI recipients in the Medicare waiting period is the most likely reason that its proportion on SSDI is substantially higher than the percentage of participants on Medicare. Third, if an SSDI recipient with Medicare coverage has earnings above the SGA level for more than nine months in a five-year period, then he or she would lose SSDI cash benefits but maintain Medicare Part A benefits for 8.5 years following the nine-month trial work period (SSA 2005). Finally, Buy-In programs authorized under the BBA 1997 can enroll working persons over age 65 with disabilities who would automatically carry Medicare regardless of SSDI status.

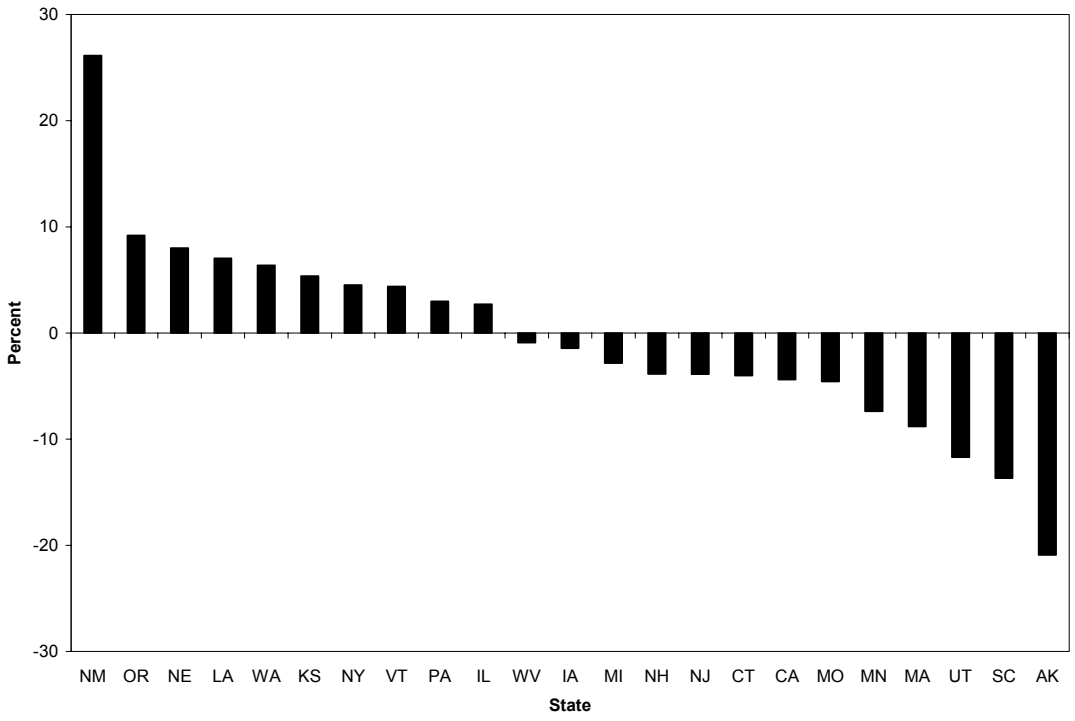
### b. Private Health Insurance

The types of private coverage carried by Buy-In participants include, in addition to Medicaid, employer-based health insurance through the participant's employer or that of his or her spouse, Medicare supplemental policies (also called "Medigap" policies), and dental insurance. Although we do not have information on the prevalence of these specific types of coverage, a recent MedPAC (2004) analysis found that 27 percent of all disabled Medicare beneficiaries had employer-sponsored insurance and that 6 percent had private Medigap insurance to supplement Medicare. The analysis suggests that employer-sponsored coverage may be the most prevalent type of private coverage, although, based on the data in MedPAC's report, it is not possible to know for sure. To encourage the take-up of private coverage, most Medicaid Buy-In programs pay private health insurance premiums if doing so is cost-effective, although state personnel noted that this is not common.

Results in Table V.2 demonstrate that the rate of private coverage among Buy-In participants ranges from 1 percent in Missouri to 30 percent in South Carolina. Several factors influence participants' carrying private coverage, including the types of jobs they hold, the overall cost of coverage in a state, and the extent to which the state promotes such coverage. One indicator for the types of jobs held by participants is a program's average earnings level. Employees with higher average earnings tend to be more likely to carry employer-sponsored coverage (AHRQ 2004), an assertion that our data support to some extent. The three states with the highest rate of private coverage in 2004 (South Carolina, Alaska, and Louisiana) ranked first, second, and seventh, respectively, in average earnings among participants with earnings (see Table V.2). Similarly, the three states with the lowest rate of private coverage (Utah, Iowa, and Missouri) ranked 21st, 24th, and 20th, respectively,

in average earnings. Furthermore, we observed a positive correlation of 0.54 between the rate of private coverage and average earnings in 2004.[10]

**Figure V.6 Difference Between the Percent of New Participants Receiving SSDI Benefits at Enrollment and the Percent of Participants Receiving Medicare in the Fourth Quarter, by State, Calendar Year 2004**




Source: State Annual Buy-In Report for 2004.

Note: Results are calculated as the percent of new participants in 2004 receiving SSDI at Buy-In enrollment minus the percent of fourth-quarter participants in Medicare while in the Buy-In program. Indiana and Wisconsin were excluded because personnel voiced concern about the accuracy of their data on SSDI status.

[10] This correlation was based on the 24 states with data on both private coverage and earnings. This correlation was 0.22 among 21 states in 2003 and 0.32 among 19 states in 2002.

**Table V.2. Relationship between Rate of Private Coverage in Addition to Medicaid and Average Earnings, 2004**

| State | Percent of Participants with Private Coverage in Addition to Medicaid | Average UI Earnings (among participants with earnings) | Rank |
|---|---|---|---|
| South Carolina | 30 | 1,531 | 1 |
| Alaska | 17 | 1,404 | 2 |
| Louisiana | 14 | 918 | 7 |
| New York | 12 | 699 | 18 |
| Oregon | 12 | 895 | 9 |
| Minnesota | 11 | 640 | 19 |
| Illinois | 11 | 732 | 13 |
| Indiana | 9 | 699 | 17 |
| Kansas | 8 | 514 | 23 |
| Wisconsin | 8 | 522 | 22 |
| California | 7 | 951 | 6 |
| Massachusetts | 6 | 1,211 | 4 |
| West Virginia | 6 | 1,179 | 5 |
| Nebraska | 6 | 762 | 12 |
| Washington | 4 | 724 | 14 |
| Vermont | 4 | 716 | 16 |
| Connecticut | 4 | 770 | 11 |
| New Mexico | 4 | 1,369 | 3 |
| New Hampshire | 4 | 720 | 15 |
| Pennsylvania | 4 | 865 | 10 |
| New Jersey | 3 | 897 | 8 |
| Utah | 2 | 567 | 21 |
| Iowa | 1 | 500 | 24 |
| Missouri | 1 | 579 | 20 |
| Correlation with percent with private coverage | | 0.54 | |

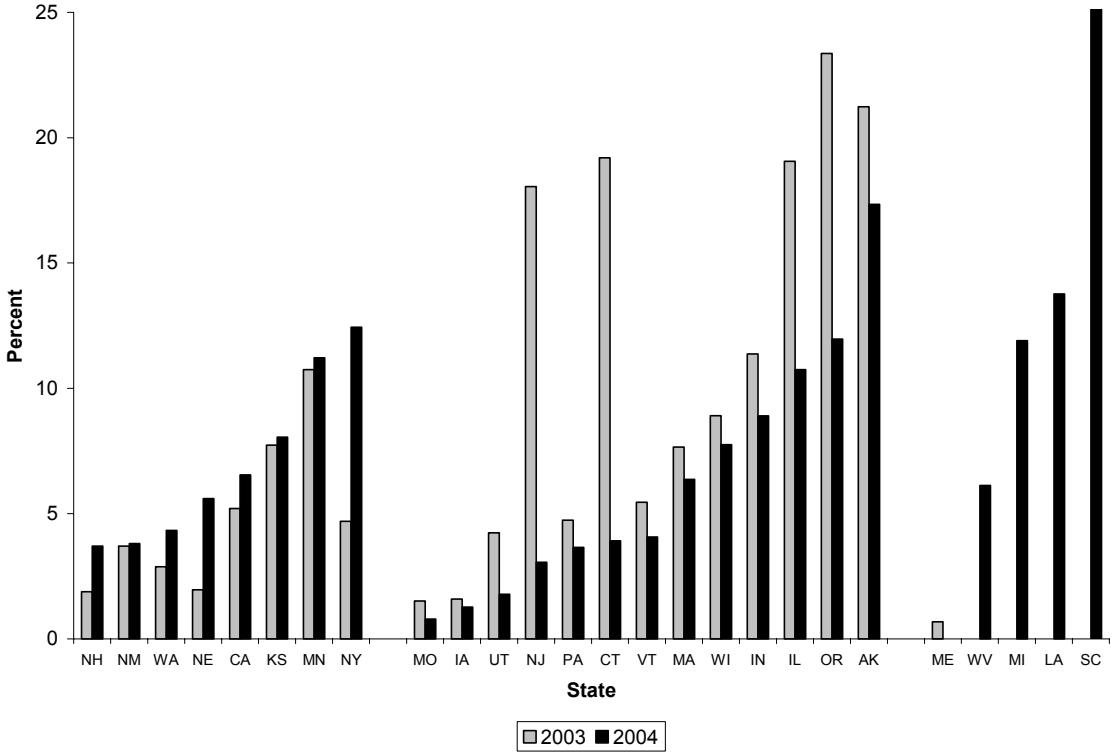
Source: State Annual Buy-In Report for 2004.

Note: States are sorted in descending order according to the percent with private coverage. Arkansas, Maine, and North Dakota did not submit data on private coverage for Buy-In participants, and Michigan did not submit earnings data. The correlation between the percent with private coverage and average UI earnings among participants with UI earnings was 0.22 in 2003 (21 states) and 0.32 in 2002 (19 states).

UI = Unemployment Insurance System

On average, and in 13 of the 21 states with data in both years, the rate of private coverage decreased between 2003 and 2004 (see Figure V.7). In several states whose rate of private coverage decreased, personnel posited that the decline could reflect a broader trend of decreasing availability of private coverage; indeed, recent research is consistent with such a theory. Private health insurance premiums and cost sharing have increased in recent years (KFF and HRET 2004), thereby making private coverage increasingly difficult to obtain (Chernew et al. 2005). Increases in cost sharing could have disproportionately adverse affects on people with disabilities because of their relatively high rates of service use. In addition, Medigap premiums increased between 2003 and 2004 (Weiss Ratings 2003, 2004). These factors might therefore result in reductions in private coverage rates among the Buy-In population. However, when we look at the change between 2002 and 2004, the proportion decreased in about half of the states (that is, 10 of 19) with data for both 2002 and 2004. The findings suggest that the decrease in most states between 2003 and 2004 could reflect random variability from one year to the next rather than the overall trend of decreasing availability of private coverage.

**Figure V.7. Percent of Buy-In Participants Covered by Medicaid and Private Coverage During the Fourth Quarter, by State, Calendar Years 2003 and 2004**




Source: State Annual Buy-In Reports for 2003 and 2004.

Note: The data refer to individuals who enrolled in the Buy-In program for the entire fourth quarter of a given year. The states that experienced an increase in the percentage of private coverage are displayed on the left in ascending order according to their 2004 percentage. States that experienced a decrease are in the middle of the figure, and states lacking data for both years are on the right of the figure. Personnel in Maine (2003) and Wisconsin (2003 and 2004) expressed concerns about the quality of their data. Arkansas, Maine, and North Dakota did not submit data.

# CHAPTER VI

# HOW MUCH ARE BUY-IN PARTICIPANTS EARNING?

The Buy-In program offers adults with disabilities an incentive to work because it allows them to retain their health benefits while increasing their earnings. It comes as no surprise, therefore, that policymakers and program personnel alike are keeping a watchful eye on participants' earnings as an indicator of program success and, by extension, its sustainability. Some states are concerned that if the average work effort of program participants drops too low, the program will become politically vulnerable insofar as low earnings are perceived as inconsistent with the program's original intent. To avoid this possibility, some states have refined their program by limiting it to individuals engaged in a more substantial work effort. Some states have done this by setting a minimum earnings requirement, and others have tightened their income-verification requirements.

A minimum earnings requirement and more stringent verification requirements could weed out very low-wage workers by reducing the number of participants who would otherwise be eligible for the program through a minimal work effort such as, according to some state personnel, babysitting or walking a neighbor's dog for a few hours each month. However, these types of changes could also exclude people who could potentially benefit from the program. An earnings minimum or a minimum wage requirement would disproportionately exclude, for example, workers in sheltered workshops who may earn well below the minimum wage and thus have low earnings despite what may be a substantial work effort (GAO 2001).[1] In addition, these workers may not be required to report income taxes (IRS 2005), so a program rule that requires verification of paid income taxes could act as another barrier to enrollment. Workers with disabilities who do not satisfy the earnings or minimum wage requirement might therefore be required to obtain Medicaid through other eligibility groups like the medically needy program or Medicaid through SSI. Federal disability policy also plays a key role in determining the average work effort of Buy-In

[1] A minimum earnings requirement would be contrary to the BBA and Ticket statutes and CMS regulations.

participants. The SSDI "cash cliff," for example, may restrain potential growth in earnings for SSDI recipients.

A fundamental question facing policymakers and program personnel concerns the *effect* of the Buy-In program on participants' work effort and whether their earnings are greater than they would have been absent the program. We cannot answer this question conclusively, as there is no rigorous empirical evidence of the program's impact, but Stapleton and Tucker (2000) suggests that, based on experience with the 1619(b) work incentive program, greater access to health coverage leads to higher employment and earnings. In addition, some studies have found that Buy-In participants' earnings increase before they enroll and decrease slightly thereafter (Chambless et al. 2005, Clark et al. 2004, Honeycutt and Harvey 2005, Thomas et al. 2005, and Tremblay and Porter 2004). The reasons for this pattern are not clear, nor are its implications for the program's effectiveness as a work incentive. However, we used aggregate-level data to observe how earnings for a cohort of participants changed over the course of a year to gain some insight into the issue of the program's effectiveness as a work incentive.

We begin this chapter by presenting earnings information for Buy-In participants at the national level and then connect variation in state-level earnings to program features like those described above and to the eligibility criteria for states' other means of obtaining Medicaid. We conclude the chapter with an aggregate-level analysis of how earnings change over time for a cohort of Buy-In participants.

## A. NATIONAL EARNINGS

Data on Buy-In participants' earnings come from each study state's Unemployment Insurance (UI) system. Although these data are consistent across states—an advantage from an analytic point of view—they could be incomplete because, for one reason or another, earnings data on some employed individuals are not present in the UI system (see Chapter I). Figure VI.1 shows that less than half (43 percent) of fourth-quarter Buy-In participants in 2004 had UI earnings. As described below, this proportion varies substantially by state, perhaps partly as a result of state variation in program features.

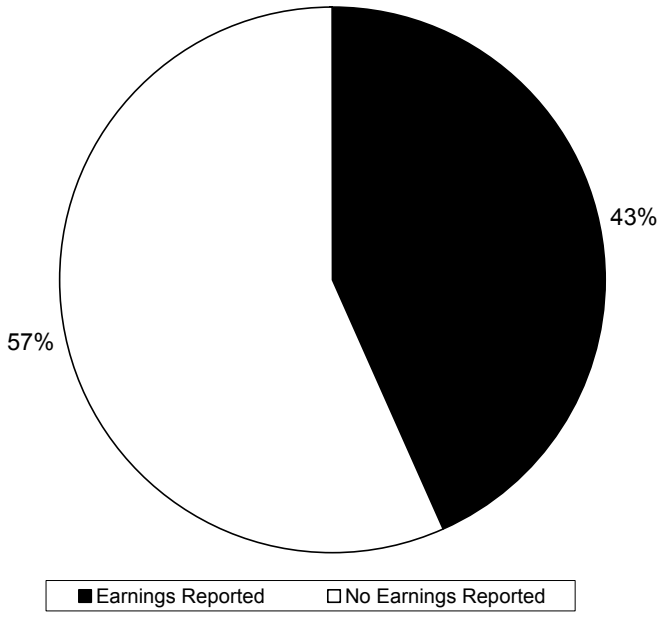
Average monthly earnings among participants with any earnings were $766 in 2004, up slightly from the previous year's average of $740.[2,3] Figure VI.2 demonstrates that, of participants with UI earnings, about 3 in 10 (32 percent) had monthly earnings above the SGA level (that is, $800 in 2003 and $810 in 2004), and 10 percent earned more than $1,600

[2] Average monthly earnings for the 19 states with data in both 2003 and 2004 were $759 in 2004 and $740 in 2003.

[3] One option, when comparing earnings data for 2003 and 2004, would be to present the information in inflation-adjusted dollars, and this would be possible for information on average earnings. However, the information states submitted on participants' earnings (see Figure VI.2) were based on nominal, rather than inflation-adjusted, earnings, which we were unable to adjust for inflation. We therefore decided to present all information in this chapter based on nominal, rather than inflation-adjusted, earnings.

per month.[4] On the other hand, among participants with UI earnings, about 7 in 10 (68 percent) had earnings below the SGA level. This may be due in part to participants' disability severity, which may prevent them from earning more. It is also possible that the SSDI "cash cliff" may be causing some individuals to deliberately keep their earnings below the SGA level to maintain SSDI cash benefits. In fact, we see that the proportion of individuals with earnings in a given category drops markedly as earnings exceed the SGA level. The proportion of individuals with earnings in categories at or below $800 per month was fairly stable, ranging from 15 to 18 percent and then decreases substantially—only 10 percent had earnings in the $801 to $1,000 category.

**Figure VI.1. Percent of Buy-In Participants with UI Earnings Reported in the Fourth Quarter of 2004, 27 States**

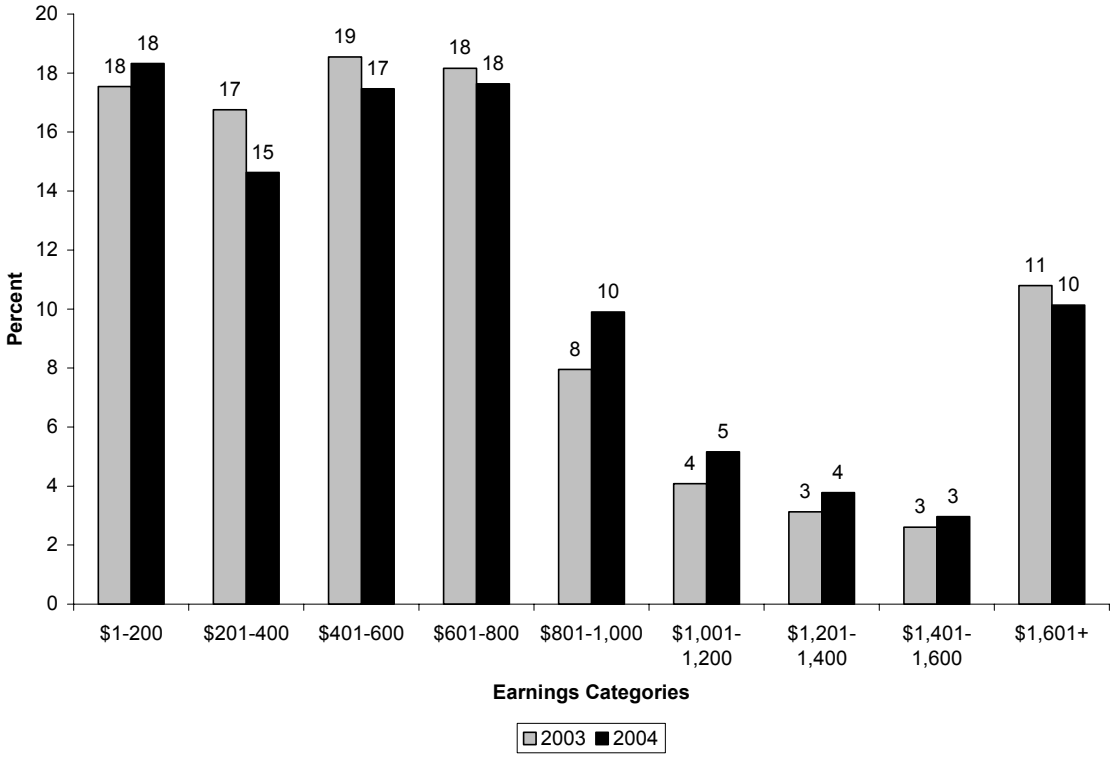



Source: State Annual Buy-In Reports for calendar year 2004.

Note: Reported UI earnings are for Buy-In participants enrolled during the entire fourth quarter of calendar year 2004. Michigan did not submit these data.

[4] The SGA level was $800 per month in 2003 and $810 in 2004.

**Figure VI.2. Percent of Buy-In Participants with Reported Monthly UI Earnings Across Selected Monthly Earnings Categories, 2003 (19 states) and 2004 (26 States)**




Source: State Annual Buy-In Reports for calendar year 2003 and 2004.

Note: Reported UI earnings are for Buy-In participants enrolled during the entire fourth quarter of calendar year 2003 or 2004. Percentage distribution may not sum to 100 due to rounding. In 2003, one state (New Jersey) did not submit earnings data and 2 states (Indiana and Pennsylvania) did not use the UI system. In 2004, Michigan and New Jersey did not submit these data.

## B. STATE EARNINGS

Our state-level analysis of Buy-In participants' earnings has two main components. First, for Buy-In participants enrolled in the fourth quarter of calendar years 2003 or 2004, we analyze the percent with earnings and average earnings and how these measures vary across states. In both cases, we connect trends we observe to program features such as a grace period and minimum earnings and income verification requirements. We also examine the prevalence of self-employment earnings in some states. We then present results for how earnings vary over time for a cohort of Buy-In participants and develop hypotheses for the patterns we observe.

### 1. Percent with UI Earnings

The proportion of participants with UI earnings in 2004 ranged from 20 percent in Missouri to 84 percent in Maine (Table VI.1). Whether a state sets an earnings minimum for initial and continued enrollment appears to be related to the proportion of participants with UI

earnings. For instance, of the three states with an earnings minimum as of December 2004 (South Carolina, Oregon, and New Mexico), the first two rank fourth and fifth, respectively, in the proportion of participants with UI earnings. New Mexico's low ranking (24th) is likely connected—at least in part—to its exemption of the employment requirement for SSDI recipients in the waiting period for Medicare.

Like the minimum earnings requirement, the requirement that participants must demonstrate income reported to the IRS or that FICA taxes are being paid appears to be connected with the proportion with UI earnings. Indeed, 9 of the 11 states with this requirement rank at or above the median of 61 percent in the proportion with UI earnings (Table VI.1).

A program's grace period and the frequency with which eligibility is redetermined are two other factors that could be related to the proportion of Buy-In participants with UI earnings. Theoretically, one might expect to see a relatively lower proportion of participants with earnings in states with a grace period because it is easier for unemployed enrollees to remain on the program. The same can be said for states that redetermine eligibility every 12 months because participants who becomes unemployed and but do not notify their eligibility worker may be able to remain enrolled for up to 12 months until the next recertification period. Despite these expectations, however, we did not observe a separate relationship between the percent with earnings and either a state's grace period or the frequency of redetermination.

### 2. Average UI Earnings

Average monthly UI earnings among participants who have earnings range from $450 in North Dakota to $1,531 in South Carolina (Table VI.2). Although an absence of detailed data on individual-level characteristics makes it difficult to determine what drives a program's average earnings level, we can hypothesize about the contributing factors on the basis of our knowledge of each program and other public assistance programs. Not surprisingly, an earnings minimum appears to be related to average earnings. All three states with an earnings minimum in 2004 (New Mexico, Oregon, and South Carolina) were in the top 10 in average UI earnings in 2004 (Table VI.2). South Carolina has the highest earnings minimum of $810 per month in 2004, and this may explain why 7 in 10 (71 percent) participants with UI earnings were above the SGA level. In addition, although Massachusetts does not have an earnings minimum, the state requires participants to work at least 40 hours per month, which could have a similar effect.

Average earnings should also be assessed in the overall context of other public assistance programs because these programs affect the pool of individuals eligible for the Buy-In program. For example, if a state has a low eligibility threshold for its medically needy program and does not extend Medicaid eligibility to people with disabilities with income below the FPL, then people with disabilities who have income below the FPL would be more likely to be eligible for the Buy-In program than are their counterparts in a similar state with a high income threshold for Medicaid groups other than the Buy-In program. This may

**Table VI.1. Percent of Buy-In Participants with UI Earnings in the Fourth Quarter of 2003 and 2004, By State**

| State | Percent with UI Earnings | | Earnings Minimum[a] | Income/FICA Tax Verification Requirements[b] | Grace Period (Months) | Redetermination Frequency (Months) |
|---|---|---|---|---|---|---|
| | 2003 | **2004** | | | | |
| Maine | 76 | **84** | | | | 12 |
| Nebraska | 77 | **81** | | | | 1 |
| Washington | 78 | **78** | | Yes | Yes (12) | 12 |
| South Carolina | N/R | **76** | Yes | Yes | | 1 |
| Oregon | 72 | **75** | Yes | | Yes[c] | 12 |
| Kansas | 78 | **74** | | Yes | Yes (6) | 6 |
| Illinois | 69 | **74** | | Yes | Yes (3) | 12 |
| New York | 73 | **72** | | Yes | Yes (6) | 12 |
| Vermont | 72 | **71** | | | | 6 |
| Louisiana | N/A | **71** | | Yes | Yes (6) | 12 |
| New Jersey | N/R | **68** | | | Yes (6.5) | 12 |
| Arkansas | N/R | **67** | | Yes | Yes (6) | 12 |
| Connecticut | 61 | **64** | | Yes | Yes (12) | 12 |
| Massachusetts | 53 | **61** | | Yes | Yes (3) | 12 |
| Pennsylvania | N/R | **60** | | | Yes (2) | 12 |
| California | 58 | **60** | | | | 6 |
| Minnesota | 55 | **58** | | | Yes (4) | 6 |
| West Virginia | N/A | **57** | | | Yes (6) | 6 |
| New Hampshire | 66 | **57** | | Yes | Yes (12) | 12 |
| Utah | 52 | **56** | | | | 12 |
| North Dakota | N/A | **56** | | | Yes[d] | 1 |
| Indiana | N/R | **54** | | Yes | Yes (12) | 12 |
| Alaska | 41 | **43** | | | | 1 |
| New Mexico | 39 | **28** | Yes | | | 12 |
| Iowa | 25 | **27** | | | Yes (6) | 1 |
| Wisconsin | 37 | **27** | | | Yes (6) | 6 |
| Missouri | 19 | **20** | | | | 12 |
| Total | 40 | **43** | | | | |

Source: State Annual Buy-In Report Form for 2003 and 2004.

Note: Data are for participants enrolled for the entire fourth quarter of 2003 or 2004. Discussions with state officials in Connecticut and Maine suggest potential inaccuracies in the 2003 data. In 2004, 40 percent of participants had UI earnings in the 19 states with data in both 2003 and 2004.

**Table VI.1 (*continued*)**

[a]State requires that individuals have a minimum earnings level to enroll and remain in the Buy-In program.
[b]A "Yes" indicates that the state requires participants to demonstrate that income or FICA taxes are being paid on earned income.
[c]Participants without earnings may remain in the program if they retain an employment relationship with their employer or are otherwise eligible for Medicaid.
[d]Enrollees may continue enrollment if they experience a job loss due to health problems.

N/A = Not applicable. Buy-In programs in Louisiana, Michigan, North Dakota, and West Virginia did not begin until 2004.

N/R = Not reported. Arkansas and South Carolina had Buy-In programs in 2003 but did not have a MIG and thus did not submit data. Data for Indiana and Pennsylvania in 2003 are not reported because these states did not use the UI system.

be what is driving average earnings in Kansas, Iowa, Missouri, and North Dakota, which do not have a poverty-related coverage group and where earnings rank 22nd or lower (Table VI.2). Conversely, Alaska and California have categorical Medicaid monthly income thresholds for people with disabilities of $1,047 and $1,026, respectively, which may partly explain the high average earnings in these states.

There are also a number of other factors, such as the prevalence of self-employment income, the underlying characteristics of the population, the state's average wage level, and the presence of a grace period that may affect average earnings in a given state. States where Buy-In participants derive a larger proportion of their income from self-employment may tend to have low UI earnings compared to other states because of the absence of self-employment earnings in UI systems. State personnel in Indiana and Minnesota noted that a large number of their participants work in day training and habilitation facilities, and these individuals could lower average earnings in these states to the extent that this income is reported in the UI system.[5]

Finally, one might expect a grace period, which allows unemployed individuals to remain on the program during periods of unemployment that arise due to health problems or a job loss, to suppress average earnings. Theoretically, grace periods should be associated with lower average earnings because individuals who are working will have gaps in their earnings that would lower overall averages. We did not find such a relationship in our analysis, perhaps because many of the individuals in a grace period did not have any reported earnings and thus were not taken into account when we calculated the average among participants with earnings in the UI system.

[5] Earnings for individuals in sheltered workshops that are not reported in the UI system would not affect average earnings, which are calculated only among participants with UI earnings.

**Table VI.2: Average Monthly UI Earnings in the Fourth Quarter of 2003 and 2004, By State**

| State | Average UI Earnings Among Participants with UI Earnings ($) | | Average Monthly Wage Among Overall Employed Population, May 2004 ($) | | Grace Period (Months) | Percent with Monthly UI Earnings Above SGA ($810) Among Participants with UI Earnings | Percent with Monthly UI Earnings Above $1,600 Among Participants with UI Earnings |
|---|---|---|---|---|---|---|---|
| | 2003 | **2004** | | Rank | | 2004 | 2004 |
| South Carolina | N/R | **1,531** | 2,647 | 22 | | 71 | 47 |
| Alaska | 1,337 | **1,404** | 3,449 | 6 | | 73 | 36 |
| New Mexico | 943 | **1,369** | 2,728 | 20 | | 56 | 26 |
| Massachusetts | 1,209 | **1,211** | 3,720 | 1 | Yes (3) | 51 | 26 |
| West Virginia | N/A | **1,179** | 2,520 | 25 | Yes (6) | 75 | 21 |
| Arkansas | N/R | **1,014** | 2,418 | 27 | Yes (6) | 53 | 23 |
| California | 984 | **951** | 3,459 | 5 | | 41 | 15 |
| Louisiana | N/A | **918** | 2,583 | 24 | Yes (6) | 43 | 17 |
| New Jersey | N/R | **897** | 3,520 | 4 | Yes (6.5) | N/R | N/R |
| Oregon | 829 | **895** | 3,031 | 11 | Yes[a] | 35 | 14 |
| Pennsylvania | N/R | **865** | 2,982 | 12 | Yes (2) | 41 | 12 |
| Maine | 1,003 | **861** | 2,745 | 19 | | 39 | 11 |
| Connecticut | 749 | **770** | 3,643 | 2 | Yes (12) | 31 | 9 |
| Nebraska | 895 | **762** | 2,723 | 21 | | 32 | 10 |
| Illinois | 612 | **732** | 3,197 | 9 | Yes (3) | 27 | 6 |
| Washington | 729 | **724** | 3,369 | 7 | Yes(12) | 27 | 8 |
| New Hampshire | 579 | **720** | 3,063 | 10 | Yes (12) | 29 | 12 |
| Vermont | 698 | **716** | 2,863 | 14 | | 31 | 5 |
| Indiana | N/R | **699** | 2,796 | 17 | Yes (12) | 34 | 8 |
| New York | 563 | **699** | 3,586 | 3 | Yes (6) | 28 | 7 |
| Minnesota | 628 | **640** | 3,283 | 8 | Yes (4) | 20 | 5 |
| Missouri | 573 | **579** | 2,844 | 15 | | 27 | 6 |
| Utah | 564 | **567** | 2,809 | 16 | | 16 | 1 |
| Wisconsin | 552 | **522** | 2,906 | 13 | Yes(6) | 15 | 3 |
| Kansas | 509 | **514** | 2,793 | 18 | Yes (6) | 15 | 3 |
| Iowa | 446 | **500** | 2,633 | 23 | Yes (6) | 15 | 3 |
| North Dakota | N/A | **450** | 2,515 | 26 | Yes[b] | 3 | 1 |
| Total | 740 | **766** | 3,205 | | | 31 | 10 |

**Table VI.2 (*continued*)**

Source: State Annual Buy-In Report Form for 2004 and the Bureau of Labor Statistics (2005a).

Note: Data are for participants enrolled for the entire fourth quarter of a given calendar year. States are presented in descending order of their average monthly earnings in 2004. Michigan did not submit these data. Discussions with state officials in Connecticut and Maine suggest potential inaccuracies with 2003 earnings data. Average earnings in 2004 for the 19 states with data in both years were $759.

[a]Participants without earnings may remain in the program if they retain an employment relationship with their employer or are otherwise eligible for Medicaid.
[b]Enrollees may continue enrollment if they experience a job loss due to health problems.

N/A = Not applicable. Buy-In programs in Louisiana, Michigan, North Dakota, and West Virginia did not begin until 2004.

N/R = Not reported. Arkansas and South Carolina had Buy-In programs in 2002 and 2003 but did not have a MIG and thus did not submit data. New Jersey did not submit earnings distribution data. Data for Indiana and Pennsylvania in 2003 are not reported because these states did not use the UI system.

### 3. Self-Employment Earnings

The UI system omits self-employment income, in addition to other sources.[6] It is therefore possible that some participants had self-employment income instead of, or in addition to UI earnings. Fifteen states reported data on self-employment earnings for their Buy-In participants in 2004 (Table VI.3). Among these states, the percent of Buy-In participants with self-employment earnings in 2004 ranged from 1 percent in Connecticut to 17 percent in Utah.[7] Monthly self-employment earnings among participants who reported them averaged $341 in 2004, ranging from $151 in North Dakota to $1,002 in New Mexico.

**Table VI.3. Monthly Self-Employment Earnings of Buy-In Participants in the Fourth Quarter of 2003 and 2004**

| | Percent with Self-Employment Earnings | | Average Self-Employment Earnings (Among Participants with Earnings) | |
|---|---|---|---|---|
| State | 2003 | **2004** | 2003 | 2004 |
| Utah | 25 | **17** | $230 | $302 |
| Vermont | 12 | **13** | 588 | 680 |
| California | 9 | **10** | 400 | 234 |
| Minnesota | 10 | **9** | 188 | 226 |
| Washington | 1 | **8** | 193 | 429 |
| New Hampshire | 5 | **7** | 258 | 294 |
| Indiana | 5 | **6** | 413 | 421 |
| Kansas | 3 | **6** | 430 | 262 |
| North Dakota | N/A | **5** | N/A | 151 |
| West Virginia | N/A | **4** | N/A | 937 |
| New Mexico | 3 | **4** | 434 | 1,002 |
| Nebraska | 5 | **3** | N/R | N/R |
| Louisiana | N/A | **3** | N/A | 586 |
| South Carolina | N/R | **2** | N/R | 289 |
| Connecticut | 1 | **1** | 370 | 414 |
| Wisconsin | 21 | **N/R** | N/R | N/R |
| Total | 4 | **2** | 145 | 341 |

Source: State Annual Buy-In Report Forms for 2003 and 2004.

Note: The Data above represent individuals enrolled for the entire fourth quarter of the given year. States are sorted in descending order of their proportion with self-employment earnings in 2004. States not listed above did not submit these data.

[6] Chapter I provides more detail about the characteristics of the UI system.

[7] Nebraska and Wisconsin were unable to provide data on average self-employment earnings in 2003, but they did provide the proportion of participants with such earnings.

N/A = Not applicable. Louisiana, North Dakota, and West Virginia did not have a Buy-In program in 2003.

N/R = Not reported. South Carolina had a program in 2003 but did not have a MIG and thus did not submit data. Wisconsin submitted these data for 2003 but did not do so far 2004.

In states that submitted data on self-employment earnings, average monthly self-employment earnings were about 56 percent lower than average UI earnings in 2004 ($341 versus $768). Lower self-employment earnings relative to UI earnings could be due in part to the possibility that UI earnings are more likely than self-employment earnings to originate from "competitive" employment. Personnel in California, Minnesota, and Wisconsin noted that some of what they classified as self-employment income comes from participants performing miscellaneous chores for friends or neighbors for low levels of compensation. Moreover, the prevalence of self-employment earnings may be related to average UI earnings. For example, Utah has the highest proportion with self-employment earnings and also ranks below the median in both the percent with UI earnings and average UI earnings.

State UI systems have the advantage of being fairly consistent across states, but this is not the case for self-employment earnings data. One source of the inconsistency of self-employment earnings data across states is the different criteria for what constitutes self-employment earnings. For example, Arkansas requires that self-employment earnings be reported to the IRS. Wisconsin, on the other hand, does not have such a requirement. Self-employment earnings may therefore include in-kind income in Wisconsin, but this would most likely not be the case in Arkansas. The inconsistency in how states define self-employment earnings limits our ability to compare average self-employment earnings across states.

## 4. Changes in Earnings for a Cohort of Buy-In Participants

The cohort of Buy-In participants we analyze in this section consists of individuals who were enrolled for the entire fourth quarter of two consecutive years—2003 *and* 2004 (what we call the longitudinal group). This group represents participants who have been in the program for an extended period of time. Because these individuals were enrolled in both periods, it is smaller than the fourth-quarter group (that is, participants enrolled for the entire fourth quarter of a given year) analyzed above. In 2003, the longitudinal group represented 73 percent of the total fourth-quarter group, this proportion decreased to 61 percent of in 2004.[8]

We begin the analysis of average earnings for this cohort of participants by looking at the proportion with UI earnings. Table VI.4 indicates that the proportion with earnings decreased in 16 of the 21 states that provided these data. Interestingly, we also found a similar pattern when we analyzed the cohort of participants enrolled in the fourth quarters of

[8] These proportions were calculated based on states with data in both 2003 and 2004.

both 2002 and 2003 (White et al. 2005). Why did this decline occur in most states? The fact that the annual unemployment rate increased between 2003 and 2004 in only 3 of the 21 states with these data (BLS 2005b) suggests that the decline in the percent with earnings in most states was not driven by a deterioration of overall economic conditions.

Another possibility is that data lags may have contributed to this decline. States extracted these data roughly around March through July of 2005, and doing so allowed for a follow-up period of three to seven months for data from the fourth quarter of 2004 and 15 to 19 months for data from the fourth quarter of 2003. The longer follow-up period for the 2003 data, which may have caused it to be more complete, could have resulted in a higher proportion of participants with earnings in 2003 relative to one year later.

Finally, the movement of participants in and out of grace periods may have contributed to the decline in the proportion with UI earnings. This explanation would not apply across all states because 6 of the 16 states in which the percent with UI earnings declined did not have a grace period. However, for the ten states that did, if one assumes that individuals who enter a grace period are more likely to disenroll from the program rather than remain on it by becoming employed, then one might expect the following two relationships to cause the proportion of participants with earnings to decrease between 2003 and 2004: (1) individuals in the grace period in the fourth quarter of 2003 would tend to disenroll (rather than begin working again) and thus not be in the longitudinal group; and (2) some individuals with UI earnings in the fourth quarter of 2003 would be in a grace period one year later. Unfortunately, it is not possible to verify the validity of these assumptions using aggregate data.

Another key measure of how earnings change over time is the average monthly earnings among participants who have them. Results in Table VI.4 indicate that average earnings increased in all but four programs in which the percent with UI earnings declined. This suggests that one of the following three scenarios may have occurred: (1) participants who dropped off of the UI system may have been low earners, and their absence in the second year caused the average to increase; (2) earnings among members of the longitudinal group increased, causing the average to go up as well; or (3) both (1) and (2). Individual-level data are needed to determine which of these scenarios occurred.

Finally, Table VI.4 illustrates how the total quarterly earnings are related to both the percent with earnings and the average monthly earnings among those who have them. For example, the percent of participants with UI earnings in Wisconsin decreased by five percent, but average monthly earnings among those who have them increased by nine percent. As a result, the percentage increase in total quarterly earnings was only three percent.

It is difficult to determine the implications of these results because we are unable to confirm or refute the potential explanations suggested above for changes in the proportion of participants with earnings and the average earnings. In addition, this analysis is not comparable to previous individual-level analyses of how participants' earnings change over time (Chambless et al. 2005, Clark et al. 2004, Honeycutt and Harvey 2005, Thomas et al. 2005, and Tremblay and Porter 2004) because they focused on how earnings change relative

to time since enrollment, whereas the cohort used for this analysis consisted of individuals with a variety of enrollment periods.

**Table VI.4. Average Monthly Earnings for the Longitudinal Group of Buy-In Participants, 2003-2004, by State**

| State | Total Longitudinal Group Participants 2003-2004 | Percent with UI Earnings | | | Average Monthly Earnings (Among Participants with Earnings) | | | Total Quarterly Earnings | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | 2003 | 2004 | **% Change** | 2003 | 2004 | % Change | 2003 | 2004 | % Change |
| New Mexico | 440 | 11 | 37 | **247** | 981 | 258 | -74 | 138,301 | 126,233 | -9 |
| Iowa | 5,164 | 23 | 30 | **31** | 433 | 506 | 17 | 1,509,032 | 2,311,893 | 53 |
| Arkansas | 28 | 71 | 71 | **0** | 896 | 982 | 10 | 53,775 | 58,895 | 10 |
| Missouri | 10,429 | 17 | 17 | **0** | 440 | 530 | 20 | 2,357,470 | 2,754,488 | 17 |
| Utah | 65 | 55 | 55 | **0** | 556 | 580 | 4 | 60,051 | 62,675 | 4 |
| Washington | 145 | 82 | 80 | **-3** | 748 | 722 | -3 | 267,194 | 251,378 | -6 |
| New Jersey | 726 | 72 | 70 | **-3** | 811 | 901 | 11 | 1,271,775 | 1,375,431 | 8 |
| Minnesota | 4,442 | 58 | 56 | **-3** | 634 | 637 | 0 | 4,876,603 | 4,731,150 | -3 |
| Maine | 294 | 86 | 83 | **-4** | 888 | 881 | -1 | 674,251 | 642,504 | -5 |
| Wisconsin | 4,248 | 36 | 34 | **-5** | 532 | 577 | 9 | 2,443,485 | 2,523,049 | 3 |
| Oregon | 396 | 77 | 73 | **-5** | 891 | 925 | 4 | 815,136 | 805,100 | -1 |
| Vermont | 225 | 71 | 67 | **-5** | 658 | 681 | 4 | 313,943 | 308,666 | -2 |
| Illinois | 300 | 79 | 75 | **-5** | 611 | 689 | 13 | 434,296 | 465,023 | 7 |
| Alaska | 90 | 40 | 38 | **-6** | 1,279 | 1,372 | 7 | 138,176 | 139,934 | 1 |
| Kansas | 481 | 80 | 75 | **-6** | 513 | 510 | -1 | 592,000 | 553,831 | -6 |
| Massachusetts | 3,891 | 70 | 63 | **-10** | 1,210 | 1,267 | 5 | 9,878,124 | 9,284,148 | -6 |
| New York | 551 | 74 | 66 | **-10** | 663 | 676 | 2 | 811,295 | 742,396 | -8 |
| Connecticut | 1,783 | 74 | 66 | **-11** | 713 | 745 | 4 | 2,805,357 | 2,609,687 | -7 |
| South Carolina | 38 | 89 | 76 | **-15** | 1,480 | 1,626 | 10 | 150,971 | 141,488 | -6 |
| Nebraska | 71 | 90 | 75 | **-17** | 843 | 753 | -11 | 161,765 | 119,801 | -26 |
| New Hampshire | 665 | 71 | 58 | **-19** | 606 | 702 | 16 | 863,197 | 810,793 | -6 |
| Total | 34,472 | 41 | 40 | -1 | 720 | 745 | 4 | 30,616,197 | 30,818,563 | 1 |

Source: State Annual Buy-In Report Form for 2004.

Note: Data above are for participants enrolled for the entire fourth quarter of 2003 *and* 2004. States are sorted in descending order of the percentage change in the proportion with UI earnings. California, Indiana, and Pennsylvania did not report these data. Discussions with state officials in Connecticut and Maine suggest potential inaccuracies with 2003 earnings data.

# CHAPTER VII

# HOW MUCH ARE PARTICIPANTS' PREMIUMS?

The Buy-In program is one of the few Medicaid eligibility groups for which states can both impose premiums and set copayments above the nominal levels allowed by traditional Medicaid (GAO 2004). This flexibility in cost-sharing allows states to (1) fashion the Buy-In program into coverage that more closely resembles products in the private market and (2) reduce the cost of the program to the states and to the federal government.

Despite the advantages afforded by this flexibility, states face a tradeoff in developing their premium and cost-sharing structures. For instance, although higher premiums have the potential to reduce the net cost of the program, but they also have the potential to reduce access to care (Ku and Wachino 2005). This chapter documents our analysis of two main outcomes of premium and other cost-sharing policies in Buy-In programs: the proportion of Buy-In participants required to pay a premium and the average premium for each program.

We focus on premiums because this form of cost-sharing makes the Buy-In program unique among the Medicaid eligibility groups. Few states have chosen to charge copayments and coinsurance above the nominal amounts for traditional Medicaid. It is noteworthy, however, that, in addition to a premium, Buy-In participants are typically responsible for the copayments and coinsurance that are often charged to all Medicaid beneficiaries in a given state.

## A. INCOME THRESHOLD FOR PREMIUMS

About 4 in 10 (38 percent) Buy-In participants pay a premium, and the share of participants required to do so varies substantially across states (Table VII.1). Seven states did not charge a premium to any fourth-quarter participants in 2004, and three of the seven (New Jersey, South Carolina, and Vermont) made this choice because the revenue from premiums did not offset the administrative costs associated with collecting them. Two other states, Arkansas and New Mexico, did not require Buy-In participants to pay a premium, but they did charge copayments that are higher than those for traditional Medicaid eligibility groups.

**Table VII.1. Percent of Participants Required to Pay a Premium, by State, 2003-2004**

| State | Total Fourth-Quarter Participants | | Income Level Above Which Premium Is Required (Percent of FPL) | Percent Required to Pay Premiums | |
|---|---|---|---|---|---|
| | 2003 | 2004 | | 2003 | **2004** |
| Washington[a] | 208 | 369 | 8[b] | 100 | **100** |
| North Dakota | N/A | 207 | 0 | N/A | **100** |
| California | 807 | 1,085 | 0[b] | 100 | **100** |
| Minnesota | 6,178 | 5,731 | 0 | 97 | **100** |
| Illinois | 446 | 558 | 100[b] | 100 | **99** |
| Pennsylvania | 2,196 | 3,721 | 0 | 70 | **94** |
| West Virginia | N/A | 49 | 0 | N/A | **94** |
| Massachusetts | 6,253 | 6,521 | 150 | 91 | **91** |
| Utah | 118 | 168 | 100 | 87 | **88** |
| Alaska | 179 | 173 | 100[b] | 63 | **65** |
| Kansas | 621 | 782 | 100[b] | 69 | **60** |
| Oregon | 565 | 543 | 200 | 2[c] | **51[c]** |
| New Hampshire | 1,110 | 1,027 | 150[b] | 29 | **32** |
| Indiana[h] | 5,006 | 5,899 | 150 | 11 | **28** |
| Iowa | 6,169 | 7,540 | 150 | 26 | **25** |
| Missouri | 13,678 | 17,126 | 150 | 14 | **16** |
| Connecticut[h] | 2,505 | 2,940 | 200 | 13 | **12** |
| Wisconsin | 5,165 | 7,092 | 150[b] | 11 | **10** |
| Louisiana | N/A | 385 | 150 | N/A | **9** |
| Maine | 733 | 591 | 150[b] | 12 | **6** |
| Nebraska | 102 | 125 | 200 | 1 | **2** |
| Arkansas[d] | N/R | 45 | N/A | N/R | **0** |
| Vermont[e] | 385 | 443 | N/A | 8 | **0** |
| Michigan | N/A | 84 | 250 | N/A | **0** |
| New Jersey[f] | 892 | 1,276 | 150[b] | 0 | **0** |
| New Mexico[d] | 890 | 1,155 | N/A[b] | 0 | **0** |
| New York[g] | 617 | 2,597 | 150 | 0 | **0** |
| South Carolina[e] | N/R | 50 | N/A | N/R | **0** |
| Total | 54,823 | 68,282 | | 38 | 38 |

Source: State Annual Buy-In Reports for 2003 and 2004.

Note: States are sorted in descending order of the percent of participants required to pay a premium in 2004. Buy-In premiums reported above are in addition to the copayments and coinsurance typically required of individuals in regular Medicaid.

[a]Washington requires a premium from individuals with over $65 of earned income. Therefore, as a percentage of the 2004 FPL of $776, the premium threshold was ($65/$776) = 0.08.

[b]Countable income includes spousal income.

[c]Percentage for 2003 does not include individuals required to pay a premium on unearned income, but the percentage for 2004 does.

**Table VII.1 (*continued*)**

[d]Arkansas and New Mexico do not require a premium, but do charge copayments that are higher than those required for traditional Medicaid. In Arkansas, the higher copayments are only required of participants with countable income above 100 percent of FPL.

[e]Buy-In participants in South Carolina are not charged a premium. Premiums in Vermont were eliminated in 2004. Vermont's premium threshold in 2003 was 185 percent of FPL.

[f]New Jersey did not require participants to pay a premium because the revenue from doing so was too small to justify the administrative costs.

[g]New York did not collect premiums in 2003 or 2004 because its billing and collections system was not operational.

[h]State personnel in Connecticut and Indiana noted that 2003 data may be inaccurate.

N/A = Not applicable. Buy-In programs in Louisiana, Michigan, North Dakota, and West Virginia did not begin until 2004.

N/R = Not reported. Arkansas and South Carolina had Buy-In programs in 2002 and 2003 but did not have a MIG and thus did not submit data.

In the 21 remaining states, the proportion of participants required to pay a premium ranged from 6 to 100 percent. Five states (California, Minnesota, North Dakota, Pennsylvania, and West Virginia) have a policy that requires all participants to pay a premium, and at least 94 percent of participants in these states were indeed required to do so (Table VII.1). The fact that this proportion was below 100 percent for Pennsylvania and West Virginia in 2004 may be due to the possibility that some participants were in the state's grace period, when the premium may be waived; and in Pennsylvania in particular, premiums of less than $10 are waived.

In other states, the share of participants required to pay a premium is related to the premium threshold (the income level at which premiums are required) and the amount of countable income. In Michigan, for example, the premium threshold is 250 percent of FPL. Therefore, the fact that no participants paid a premium in the fourth quarter of 2004 suggests that the countable income of all participants was below this level. On the other hand, Washington requires participants with countable income above $65 per month (that is, 8 percent of FPL) to pay a premium, and it appears that all participants have income above this level.

## B. PREMIUM AMOUNT

As a cost-sharing device, premiums have the potential to offset the growth of overall Medicaid expenditures. However, states are limited in their ability to use premiums and other cost-sharing methods to do this because a portion of the revenue is returned to CMS. Because each state has its own formula for calculating the premium amount, cross-state differences in the average premium paid are not a surprise. The amount ranges from $13 per month in Maine to $162 per month in Utah (Table VII.3). One difference between the enabling legislation for the Buy-In program in the BBA and in the Ticket Act is that the latter capped participants' cost sharing at 7.5 percent of gross income. It is therefore likely that the four states with the highest average premiums among premium payers in 2004 (Utah, Wisconsin, Oregon, and Nebraska) structured their premiums on the basis of the additional flexibility authorized under the BBA.

It is also reasonable to assume that some states, especially those that do not charge a premium, are not using their cost-sharing policy as a significant source of revenue.[1] However, this is not the case in Utah where, in 2002, the state legislature responded to budget pressures by demanding either a substantial increase in premiums or possibly even the elimination of the program altogether. As a result, the state increased its premium in 2002 from 20 percent of countable income to a sliding scale of 30 to 55 percent. When Utah's fiscal problems subsided somewhat in the following year, the state lowered its premium to 15 percent of countable income.

[1] Two states that do not charge a premium (Arkansas and New Mexico) receive some revenue from the higher copayments and coinsurance they charge of Buy-In participants relative to other Medicaid beneficiaries.

To examine the extent to which premiums offset the cost of the program, we looked at the average premium paid by all participants as a percentage of Medicaid expenditures per member per month (PMPM).[2] In Utah and Washington, premium payments per enrollee were 11 and 15 percent of Medicaid expenditures, respectively, and as described above, Utah viewed its premium as mechanism for reducing program costs. In three other states (Illinois, Massachusetts, and Oregon), premium payments constituted seven percent of Medicaid expenditures, and in the remaining states, they were five percent or less.

[2] We do not have information on the administrative cost required to collect premiums, so the net revenue to the state from premiums would be lower than the average premium among all participants in Table VII.2.

**Table VII.2. Monthly Premiums, by State, 2003-2004**

| | Percent Required to Pay Premiums | | Average Premium (among premium payers) | | Average Premium (among all participants) | | Percent of PMPM Medicaid Expenditures, 2004 |
|---|---|---|---|---|---|---|---|
| | 2003 | 2004 | 2003 | **2004** | 2003 | 2004 | |
| Utah | 87% | 88% | $145 | **$162** | $127 | $142 | 11% |
| Wisconsin | 11 | 10 | 139 | **143** | 15 | 14 | 1 |
| Oregon | 2[a] | 51[a] | 45[a] | **103**[a] | 1 | 52 | 7 |
| Washington | 100 | 100 | 82 | **86** | 82 | 86 | 15 |
| Nebraska | 1 | 2 | 111 | **101** | 1 | 2 | 0 |
| Louisiana | N/A | 9 | N/A | **77** | N/A | 7 | 1 |
| Indiana[f] | 11 | 28 | 82 | **74** | 9 | 21 | 1 |
| Kansas | 69 | 60 | 62 | **71** | 43 | 42 | 5 |
| Missouri | 14 | 16 | 66 | **69** | 10 | 11 | 1 |
| North Dakota | N/A | 100 | N/A | **58** | N/A | 58 | 3 |
| Minnesota | 97 | 100 | 44 | **56** | 43 | 56 | 3 |
| Illinois | 100 | 99 | 48 | **51** | 48 | 51 | 7 |
| Massachusetts | 91 | 91 | 50 | **47** | 45 | 43 | 7 |
| Pennsylvania | 70 | 94 | 40 | **46** | 28 | 43 | 5 |
| Iowa | 26 | 25 | 36 | **39** | 9 | 10 | 1 |
| Connecticut[f] | 13 | 12 | 49 | **37** | 7 | 5 | 0 |
| New Hampshire | 29 | 32 | 34 | **37** | 10 | 12 | 1 |
| Alaska | 63 | 65 | 13 | **35** | 8 | 23 | 2 |
| California | 100 | 100 | 30 | **31** | 30 | 31 | 4 |
| West Virginia | N/A | 94 | N/A | **26** | N/A | 24 | 3 |
| Maine | 12 | 6 | 13 | **13** | 2 | 1 | 0 |
| Arkansas[c] | N/R | 0 | N/R | **0** | N/R | 0 | 0 |
| Michigan | N/A | 0 | N/A | **0** | N/A | 0 | 0 |
| New Jersey[b] | 0 | 0 | 0 | **0** | 0 | 0 | 0 |
| New Mexico[c] | 0 | 0 | 0 | **0** | 0 | 0 | 0 |
| New York[d] | 0 | 0 | 0 | **0** | 0 | 0 | 0 |
| South Carolina[e] | N/R | 0 | N/R | **0** | N/R | 0 | 0 |
| Vermont[e] | 8 | 0 | 27 | **0** | 2 | 0 | 0 |
| Total | 38% | 38% | $51 | $56 | $19 | $22 | |

Source: State Annual Buy-In Reports for 2003 and 2004.

Note: States are sorted in descending order according to the average premium among premium payers in 2004. Buy-In premiums reported above are in addition to the copayments and coinsurance typically required of individuals in regular Medicaid.

[a]Percentage of premium payers and the average premium for 2003 does not include individuals required to pay a premium on unearned income, but the percentage for 2004 does.

[b]New Jersey did not require participants to pay a premium because the revenue from doing so was too small to justify the administrative costs.

**Table VII.2 (*continued*)**

[c]Arkansas and New Mexico do not require a premium but do charge copayments that are higher than those for regular Medicaid.

[d]New York did not collect premiums in 2003 or 2004 because its billing and collections system was not operational.

[e]Buy-In participants in South Carolina are not charged a premium. Premiums in Vermont were eliminated in 2004. Vermont's premium threshold in 2003 was 185 percent of FPL.

[f]State personnel in Connecticut noted that 2003 data may be inaccurate.

N/A = Not applicable. Buy-In programs in Louisiana, Michigan, North Dakota, and West Virginia did not begin until 2004.

N/R = Not reported. Arkansas and South Carolina had Buy-In programs in 2003 but did not have a MIG and thus did not submit data.

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# CHAPTER VIII

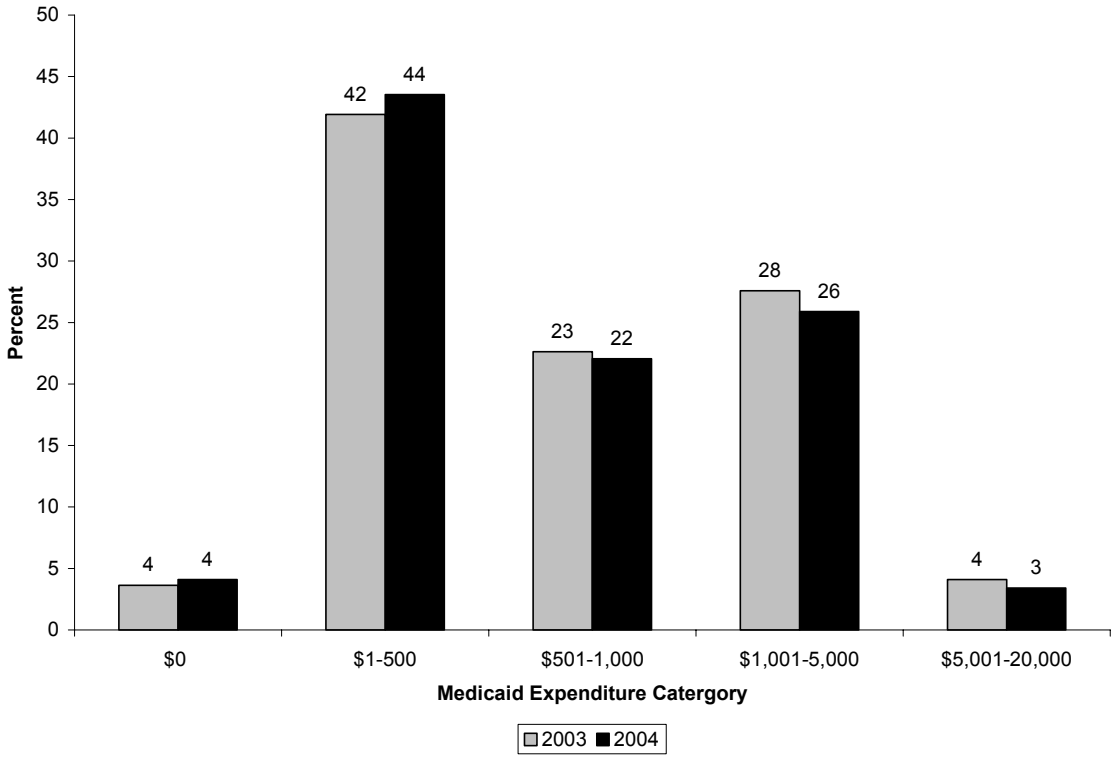
# HOW MUCH ARE PARTICIPANTS' MEDICAID EXPENDITURES?

Concern over the rising cost of health care has motivated the majority of states to increase their efforts to control Medicaid expenditures. In FY 2004, for example, 43 states planned to control drug costs, 39 planned to reduce or freeze provider payment rates, and 18 planned to restrict eligibility (Smith et al. 2004). To prevent more austere changes in the Medicaid program, the federal government provided $20 billion in financial relief to states in FY 2004 (Kaiser Commission on Medicaid and the Uninsured 2005). As a component of Medicaid, the Buy-In program has not been immune to pressure to contain Medicaid expenditures. Utah, for example, raised premiums in 2002 partly to offset program costs, and Missouri eliminated its program entirely as of August 2005.

Medicaid expenditures for Buy-In participants are determined largely by two factors. First, the cost of providing Medicaid coverage in a given state may affect PMPM expenditures. For instance, Medicaid provider reimbursements differ across states, as do the optional services they cover. The second key factor is the health-related characteristics of program enrollees. For example, some states may not allow individuals with very low earnings to enroll. Research suggests that higher earnings are associated with better health, so we might expect aggregate data from Buy-In programs to show that states with higher average earnings have lower Medicaid expenditures because their participants are in better health (Lantz et al. 1998). Also, PMPM expenditures of Buy-In participants in some states who had Medicaid coverage before they enrolled in the Buy-In program were higher, on average, than the PMPM expenditures of their counterparts who were not previously covered by Medicaid (Clark et al. 2004, Tremblay and Porter 2004, Clark et al. 2003). Therefore, the extent to which Buy-In participants transferred into the program from other Medicaid eligibility groups may be related to Buy-In PMPM expenditures.

Figure VIII.1 presents the distribution of PMPM Medicaid expenditures for Buy-In participants at the national level. It illustrates that expenditures changed little from 2003 to

**Figure VIII.1. Percent of Buy-In Participants by Category of Monthly Medicaid Expenditures, 2003 (22 States) and 2004 (28 States)**




Source: State Annual Buy-In Report Form for 2003 and 2004.

Note: The data above are for individuals enrolled for the entire fourth quarter of either 2003 or 2004. Less than one-half of one percent had monthly expenditures over $20,000. Percentages may not sum to 100 for a given year due to rounding and the omission of the over $20,000 category. Of the six states without 2003 data, four did not begin their program until 2004 (Louisiana, Michigan, North Dakota, and West Virginia). The remaining two states (Arkansas and South Carolina) had a program in 2003 but did not have a MIG and thus did not submit data. The distribution in 2004 is as follows for the 22 states with data in both 2003 and 2004: $0 (4 percent), $1-500 (43 percent), $501–1,000 (22 percent), $1,001–$5,000 (26 percent), and $5,00–20,000 (3 percent).

2004.[1] In addition, for about half of the Buy-In participants enrolled in the fourth quarter of 2005, PMPM Medicaid expenditures were less than $500 on average.

Figure VIII.2 demonstrates the substantial cross-state variability in PMPM Medicaid expenditures for Buy-In participants, which may be related to state differences in the underlying cost of providing Medicaid coverage to people with disabilities. High underlying costs in certain states could cause PMPM Medicaid expenditures for Buy-In participants to

[1] The distribution for the 22 states with data in both 2003 and 2004 was similar in both years.

be relatively high in those states. To explore the relationship between Medicaid expenditures for Buy-In participants and the underlying cost of Medicaid coverage in a state, we ranked states' PMPM Medicaid expenditures for the overall blind and disabled population (hereafter, "overall PMPM expenditures"), as shown in Table VIII.1. We find that, of the top five states in terms of overall PMPM expenditures, three rank fourth or above in this measure for Buy-In participants. Furthermore, four of the five states with the lowest overall PMPM expenditures rank below the median expenditures for Buy-In participants among the 21 states with 2002 data. This suggests that the underlying cost of providing Medicaid coverage to the blind and disabled population may be driving some of the cross-state variation observed in PMPM Medicaid expenditures for Buy-In participants.

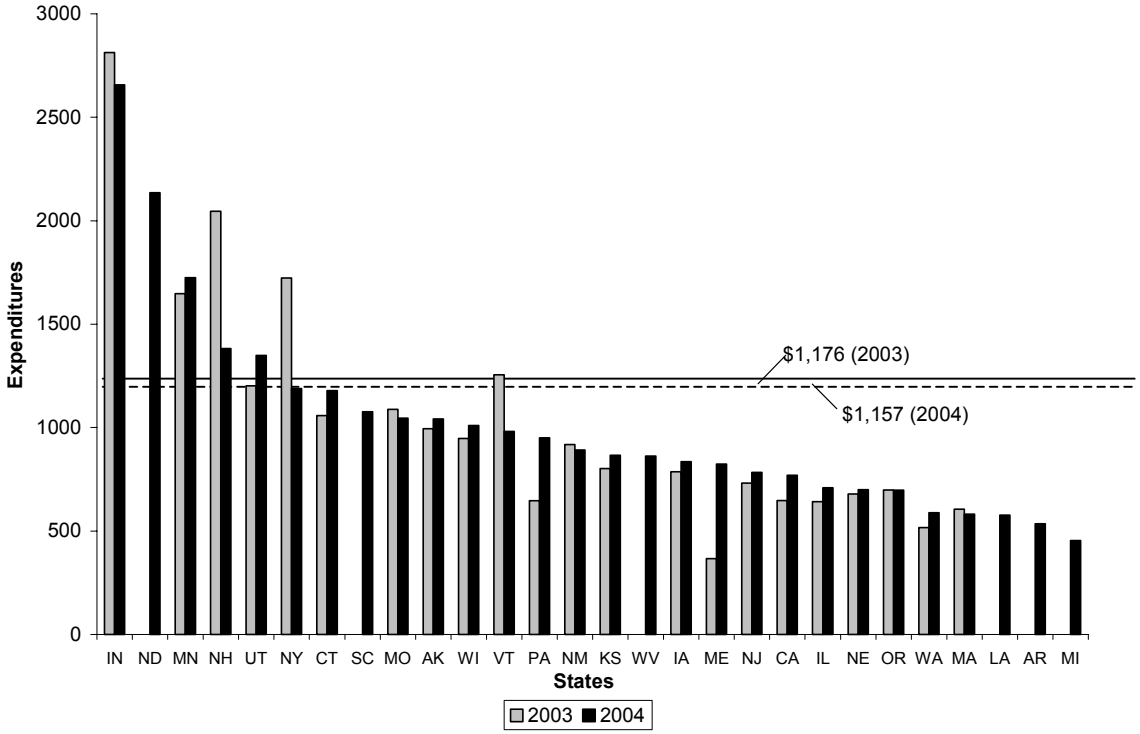
Population differences across the Buy-In program population may also affect PMPM expenditures, and average earnings levels may reflect these differences. For example, an evaluation of Wisconsin's Buy-In program found that high-wage earners have lower average Medicaid expenditures than low-wage earners (APS Healthcare 2003). Similarly, personnel in Massachusetts noted that their 40 hour monthly work requirement may contribute to their low PMPM Medicaid expenditures relative to other states. To examine the extent to which this relationship also appears in state-level aggregate data, we calculated average monthly UI earnings for *all* Buy-In participants and compared this to PMPM Medicaid expenditures (Table VIII.2).[2] All five states with the highest PMPM expenditures rank low in average earnings among all participants (that is, 18th or below out of the 27 states with earnings data). Similarly, four of the five states with the lowest PMPM expenditures (and that also have earnings data) rank high in average earnings (that is, seventh or above). This finding is consistent with the negative correlation we observed between PMPM Medicaid expenditures and average earnings of –0.37. In this case, earnings is only a proxy for underlying population differences. Analysis at the individual-level would be required to determine what individual demographic or health status characteristics are driving differences in PMPM Medicaid expenditures.

Finally, one might expect the proportion of Buy-In participants dually enrolled in Medicare to have lower PMPM Medicaid expenditures because for some of these individuals, Medicaid only pays for services that Medicare does not cover (Holahan and Ghosh 2005).[3] However, when we compared states' proportion of Buy-In participants to average PMPM expenditures, we did not find a compelling relationship.

[2] Monthly earnings among all Buy-In participants is calculated as total UI earnings divided by the total number of fourth quarter participants. This measure is different from that used in Chapter VI, which looked at average earnings among participants with UI earnings. We use average monthly earnings among all participants in this chapter so that the earnings measure and PMPM Medicaid expenditures are based on the same population (that is, the entire fourth-quarter group). This earnings measure understates average earnings in a given state because the UI system does not include some types of earnings (e.g., self-employment income). See Chapter I for more information about the UI system.

[3] Personal assistance services and prescription drugs (until January 2006 when Medicare's prescription drug benefit begins) are two areas in which Medicare generally does not provide coverage.

**Figure VIII.2. Average Monthly Medicaid Expenditures for Buy-In Participants in the Fourth Quarter of 2003 and 2004**




Source: State Annual Buy-In Report Form for 2003 and 2004.

Note: Medicaid expenditures are measured in terms of PMPM. The dotted line represents the mean across the 28 states for 2004. The solid line represents the mean across the 22 states for 2003. The data above are for individuals enrolled for the entire fourth quarter of either 2003 or 2004. State personnel in Maine noted that Medicaid expenditure data for 2003 may be underestimated because of the omission of prescription drug costs. Personnel in New Hampshire believed the change in expenditures between 2003 and 2004 reflected the transfer of home and community-based care service costs from the Buy-In program to waiver programs, which occurred in 2004. Of the six states without 2003 data, four did not begin their program until 2004 (Louisiana, Michigan, North Dakota and West Virginia). The remaining two (Arkansas and South Carolina) had a Buy-In program but did not have a MIG and thus did not submit data.

**Table VIII.1. 2002 Medicaid PMPM Expenditures for Overall Blind/Disabled Population and for Buy-In Participants, by State**

| State | 2002 PMPM Medicaid Expenditures for Blind/Disabled from MSIS | 2002 PMPM Medicaid Expenditures for Buy-In Participants | |
|---|---|---|---|
| | | $ | Rank) |
| **States with 2002 Data on Buy-In Participants** | | | |
| Minnesota | $1,739 | $1,467 | 4 |
| Connecticut | 1,732 | 1,616 | 2 |
| Alaska | 1,704 | 572 | 16 |
| New Hampshire | 1,644 | 1,602 | 3 |
| Nebraska | 1,303 | 605 | 14 |
| New Jersey | 1,267 | 1,128 | 6 |
| Utah | 1,258 | 1,372 | 5 |
| Illinois | 1,145 | 575 | 15 |
| Indiana | 1,112 | 2,260 | 1 |
| Kansas | 1,108 | 609 | 13 |
| Wisconsin | 1,087 | 919 | 9 |
| Massachusetts | 1,085 | 441 | 20 |
| Iowa | 1,063 | 722 | 11 |
| Vermont | 1,018 | 980 | 7 |
| Missouri | 902 | 950 | 8 |
| California | 899 | 559 | 17 |
| Oregon | 848 | 690 | 12 |
| Pennsylvania | 758 | 260 | 21 |
| Washington | 612 | 551 | 18 |
| Maine | 596 | 505 | 19 |
| New Mexico | 262 | 854 | 10 |
| **Total** | **$1,046** | **$1,186** | |
| **States Without 2002 Data on Buy-In Participants** | | | |
| New York | $1,835 | | |
| North Dakota | 1,399 | | |
| South Carolina | 760 | | |
| Louisiana | 710 | | |
| Arkansas | 695 | | |
| West Virginia | 662 | | |
| Michigan | 505 | | |

Sources: State Annual Buy-In Report Form for 2002 and the author's calculations of PMPM Medicaid expenditures for the overall blind and disabled population based on the Medicaid Statistical Information System (MSIS) for 2002 (CMS 2005d).

Note: PMPM Medicaid expenditures among all blind and disabled Medicaid beneficiaries were calculated based on Tables 4 and 16 of Medicaid Statistical Information System (MSIS) tabulations (CMS 2005d). To make the averages comparable, both measures are weighted based on the number of fourth-quarter Buy-In participants in 2002. PMPM information from MSIS do not include the cost of Medicare Part B premiums. In addition PMPM expenditure data from

MSIS are based on Medicaid claims paid in 2002 and thus may include costs for services rendered prior to FY 2002 and may not include costs for services rendered in FY 2002 that were processed after that year. The states without 2002 data on PMPM expenditures for Buy-In participants either did not have a Buy-In program at that time (Louisiana, Michigan, New York, North Dakota, and West Virginia) or had a program but did not have a MIG (Arkansas and South Carolina) and thus did not submit data.

**Table VIII.2. PMPM Medicaid Expenditures for All Buy-In Participants Relative to Average Monthly Earnings**

| | Average PMPM Medicaid Expenditures | Average Monthly Earnings Among All Buy-In Participants (Rank) | |
|---|---|---|---|
| State | 2004 | 2004 | Rank |
| Indiana | **$2,657** | $379 | 21 |
| North Dakota | **2,136** | 250 | 24 |
| Minnesota | **1,725** | 371 | 22 |
| New Hampshire | **1,382** | 410 | 18 |
| Utah | **1,348** | 317 | 23 |
| New York | **1,189** | 506 | 15 |
| Connecticut | **1,178** | 496 | 17 |
| South Carolina | **1,077** | 1,164 | 1 |
| Missouri | **1,045** | 115 | 27 |
| Alaska | **1,041** | 601 | 10 |
| Wisconsin | **1,010** | 139 | 25 |
| Vermont | **982** | 506 | 16 |
| Pennsylvania | **950** | 519 | 14 |
| New Mexico | **892** | 390 | 19 |
| Kansas | **866** | 382 | 20 |
| West Virginia | **862** | 673 | 5 |
| Iowa | **835** | 134 | 26 |
| Maine[a] | **823** | 720 | 3 |
| New Jersey | **783** | 611 | 9 |
| California | **770** | 570 | 11 |
| Illinois | **709** | 544 | 13 |
| Nebraska | **700** | 616 | 8 |
| Oregon | **697** | 671 | 6 |
| Washington | **589** | 567 | 12 |
| Massachusetts | **582** | 740 | 2 |
| Louisiana | **577** | 649 | 7 |
| Arkansas | **535** | 676 | 4 |
| Michigan | **454** | N/R | |
| Total | $1,157 | $331 | |
| **Correlation with Medicaid expenditures** | | **-0.37** | |

Source: State Annual Buy-In Report Form for 2004.

Note: Data above are for participants enrolled for the entire fourth quarter of the given year. States are sorted in descending order of the average PMPM Medicaid expenditures in 2004. The correlation between average PMPM Medicaid expenditures and average monthly earnings among all Buy-In participants for 2003 is –0.27.

[a]State personnel in Maine noted that Medicaid expenditure data for 2003 did not include prescription drug costs, which are a substantial proportion of total expenditures.

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# CHAPTER IX

# SUMMARY AND NEXT STEPS

The Medicaid Buy-In program is part of a broader federal effort to improve employment outcomes among people with disabilities. Toward this end, it provides these adults with an incentive to work by allowing them to keep their Medicaid coverage while sustaining a greater work effort. The federal legislation that created the program gives states the flexibility to mold the program to the context of their other public assistance programs. As a result, the structure and functioning of Buy-In programs vary across states. This variation provides policymakers and program administrators with a "natural laboratory" in which to identify the effect of different strategies implemented under different conditions.

This report reflects CMS's continuing effort to monitor participation in the states' Medicaid Buy-In programs by quantitatively documenting national and state-level enrollment trends along with participant characteristics, earnings, and expenditures. These aggregate data are augmented by qualitative information gathered through telephone discussions with state personnel, which provide insight into the implications of the quantitative findings. Together, these two sources of information—the "what" and the "why"—build a better understanding of how Buy-In program features interact with the federal and state policy context to affect patterns of enrollment and participation.

## A. SUMMARY OF FINDINGS

Our findings on Buy-In enrollment and participation, organized by the six original study questions, provide both a profile of the program at the national-level and a snapshot of extensive state-level program variation and the factors that may contribute to it.

1. ***Is the Buy-In program growing?*** The program continued to grow steadily in 2003 and 2004, primarily as a result of growth in existing programs as opposed to the addition of new ones. Enrollment as of December 2004 ranged from 5 in Wyoming to 18,610 in Missouri. Factors such as policy choices and outreach are among those that can affect how quickly programs grow. It is clear that Missouri's decision to eliminate its program as of August 2005 will markedly change the national complexion of the program.

2. ***Who participates in the Buy-In program?*** About two-thirds (65 percent) of new Buy-In participants in 2004 were in another Medicaid eligibility group before they enrolled, and about three-fourths (73 percent) were receiving SSDI benefits when they enrolled. In addition, about three-fourths (76 percent) of participants in the fourth quarter of 2004 were dually enrolled in Medicare, and a small minority (5 percent) had private coverage. The proportion of participants with prior Medicaid eligibility ranged from 30 percent in Missouri to 100 percent in Michigan, the proportion receiving SSDI benefits at enrollment ranged from 9 percent in West Virginia to 100 percent in Nebraska, the proportion with dual enrollment in Medicare and the Buy-In ranged from 10 percent in West Virginia to 94 percent in Michigan, and the proportion enrolled in a private plan while on the Buy-In ranged from 1 percent in Missouri to 30 percent in South Carolina.

3. ***How much are Buy-In participants earning?*** The earnings of about 4 in 10 (43 percent) Buy-In participants in the fourth quarter of 2004 were reflected in their state's UI system. In this group, 32 percent of participants had monthly earnings above the SGA level, and 10 percent earned more than $1,600 per month. On the other hand, about 7 in 10 (68 percent) had monthly earnings below the SGA level ($810 in 2004). This may be due in part to participants' disability severity, which may prevent them from earning more. It is also possible that the SSDI "cash cliff" may be causing some individuals to deliberately keep their earnings below the SGA level to maintain SSDI cash benefits. Average monthly UI earnings among those with earnings ranged from $450 in North Dakota to $1,531 in South Carolina.

4. ***How much are Buy-In participants' premiums?*** About 4 in 10 (38 percent) Buy-In participants paid a premium in the fourth quarter of 2004, and this proportion varied from 0 percent in seven states to 100 percent in four states. The average monthly premium amount among participants who paid a premium averaged $56 and ranged from $13 in Maine to $162 in Utah.

5. ***What are Buy-In participants' Medicaid expenditures?*** Overall, Medicaid PMPM expenditures were $1,176 in the fourth-quarter of 2004 and ranged from $454 in Michigan to $2,657 in Indiana. About half (48 percent) of Buy-In participants had average PMPM expenditures below $500.

## B. RELATIONSHIP BETWEEN PROGRAM DESIGN AND OUTCOMES

The outcomes of the Buy-In program are the product of a complex interaction between its features and its environment.[1] It is not possible, based on aggregate data alone, to isolate the independent effect of a single factor. However, aggregate data are useful for exploring

[1] Jensen et al. (2002) provides a comprehensive discussion of the tradeoffs states face when designing their program.

the relationships between program characteristics, context, and outcomes. We used the aggregate data and information from discussions with state personnel to explore the relationship between the Buy-In program and three outcomes: program enrollment, earnings, and medical expenditures.

### 1. Enrollment

**Income and Asset Eligibility Criteria**. Our analyses are consistent with the expectation that income criteria are associated with enrollment. Specifically, we found that states with a high income threshold had higher "program penetration," and vice versa.[2] In addition, limits on unearned income appear to be related to enrollment levels, which is not surprising given that such limits directly affect Buy-In program eligibility of SSDI recipients.

**Premium Structure.** A program's premium requirements can directly affect an individual's decision to enroll and thus the program enrollment level overall. For example, state personnel in Utah noted that the substantial drop in program enrollment that occurred in late 2002 was a direct response to a premium increase.

**Grace Period.** As one would expect, the presence of a grace period appears to be associated with more stable enrollment. Among participants who were ever enrolled in a given year, a larger proportion were continuously enrolled for the entire year in states with a grace period.

**Other Medicaid Eligibility Groups.** The state-specific eligibility criteria for other Medicaid groups are likely to affect the pool of individuals eligible for the Buy-In program. In general, a state that has a wide range of Medicaid options for working people with disabilities should have lower Buy-In enrollment than a similar state that does not offer such options. We found some evidence for this relationship.

**Outreach and Other Factors**. Outreach efforts can affect enrollment levels by informing eligible people with disabilities, eligibility workers, and the advocacy community about the Buy-In program. Personnel in some states noted that their relatively high enrollment level after the program's first year was tied, in part, to their outreach effort. Other factors, such as the efficiency of the enrollment process, can also play a role in a program's growth rate.

### 2. Earnings

**Income Verification**. Earnings reported to state UI systems, the data source for our earnings analysis, come only from employers covered by UI. Therefore, UI earnings tend to reflect more traditional employment as opposed to "casual" or in-kind labor such as yard work performed by an individual. We found that states requiring participants to document

[2] The program penetration rate is defined as program enrollment per 100,000 working age state residents.

income or FICA taxes tended to have a higher proportion of Buy-In participants with earnings in the UI system.

**Earnings Minimum**. In 2004, three states (New Mexico, Oregon, and South Carolina) required participants to maintain a minimum earnings level to enroll or remain in the program, and one other state (Massachusetts) mandated a minimum number of work hours.[3] Not surprisingly, participants in all of these states tended to have average earnings that were higher than average earnings in most of the other states.

### 3. Medicaid Expenditures

**Cost of Medicaid.** States vary markedly in terms of factors such as underlying costs of providing Medicaid and the health and disability status of Buy-In participants. One measure that reflects the underlying cost of Medicaid is the average PMPM Medicaid expenditures for all blind and disabled Medicaid beneficiaries. For example, any given state with high Medicaid reimbursement rates and that covers a large number of optional Medicaid services compared to other states might have relatively high PMPM Medicaid expenditures for its overall blind and disabled population. These high underlying costs could push up PMPM Medicaid expenditures for Buy-In participants. We found that states with high overall PMPM expenditures overall also tended to have high expenditures for its Buy-In program. This suggests that the underlying cost of providing Medicaid in a given state may drive some of the cross-state differences in Buy-In participants' PMPM expenditures.

**Expenditures and Earnings**. Our analyses support findings from an earlier study suggesting that individuals in better health having higher earnings (Lantz et al. 1998). We found that states reporting high average earnings for participants tended to report lower PMPM expenditures. Additional research (see "Next Steps" below) could provide insight into which individual characteristics (for example, disability type) may be driving expenditures.

## C. NEXT STEPS

Our analyses of aggregate-level data is limited to the hypotheses we can develop on the basis of observed relationships between program outcomes and program characteristics and context. However, a rigorous analysis of these relationships at the individual level, largely absent from the disability literature, would enhance the knowledge base in this area substantially. Armed with empirical evidence on program impacts, stakeholders from federal and state policymakers to the disability advocacy community would have the information they need to improve the program.

[3] The state-imposed minimum earnings requirements in New Mexico, Oregon and South Carolina are contrary to the BBA and Ticket statutes and CMS regulations. Massachusetts was able to establish a minimum work requirement because its program was implemented through an 1115 Medicaid demonstration waiver.

A wide range of issues could be addressed by more comprehensive studies undertaken either at the national level or by individual states themselves. Indeed, some states have initiated well-designed studies of critical topics, but additional evaluation is needed to examine a range of key questions, including:

- ***Is the Buy-In program successful at providing a work incentive for people with disabilities?*** The fact that the Buy-In program has existed for a number of years in some states begs the question: Do Buy-In participants work more or in higher-paying jobs than they would have absent the program? An investigation into this question might also reveal which factors, if any, undermine the work incentive inherent in the Buy-In program. For example, would enrollees work more or seek higher-paying jobs if the SSDI "cash cliff" were not an issue?

- ***How can states use program eligibility criteria to more effectively target particular groups of people with disabilities?*** States face the difficult task of meeting the needs of the diverse population of working people with disabilities, some of whom may be capable of a substantial work effort, whereas others may be able to work for only a limited amount of time or in a less demanding job. Many states are tightening their eligibility rules to encourage individuals in more competitive jobs to enroll in the program. The advantage of this approach is that it targets the program to those for whom it may have been originally intended; on the downside, it excludes individuals who need a limited exposure to employment as an introduction to the workforce. It is important to understand the implications of states' policy choices on the program's ability to meet the needs of different subgroups of working age adults with disabilities.

- ***How does the Buy-In program affect state Medicaid expenditures?*** This question is one of key interest to policymakers faced with rising Medicaid costs. Our analysis allowed us to determine the proportion of Buy-In participants who had Medicaid coverage before they enrolled in the program. Individuals who transferred into the Buy-In program from other Medicaid eligibility groups may be cost-neutral to the state, whereas those who enter the program from outside of Medicaid would raise expenditures. An individual-level analysis of this issue could help policymakers navigate the now cloudy fiscal waters by showing what Medicaid expenditures for Buy-In participants would have been in the absence of the program.

- ***To what extent does the Buy-In program function as a transition from public to private health insurance?*** The duration of participation in the Buy-In program and the coverage secured by participants after leaving the program have important implications for their access to care. For example, if a Buy-In participant becomes uninsured or receives inadequate coverage after leaving the program, their access to care could be jeopardized. Leaving the Buy-In program could also be a good outcome if an individual diminishes his or her reliance on public assistance by obtaining employer-based coverage. A thorough analysis of

Buy-In enrollment spells would improve our overall understanding of whether and how the program functions as a transition from public to private health insurance and, by extension, from economic dependence to independence.

- ***How will Medicare's Part D drug benefit affect enrollment in the Buy-In program?*** People enroll in the Buy-In program for a variety of reasons. Some need the personal-assistance services that are provided by Medicaid and not available through other sources of coverage. Many others have Medicare but need Medicaid coverage for prescription drugs benefits. Medicare's Part D drug benefit could have a profound impact on the Buy-In program and its participants, about three-fourths of whom are enrolled in Medicare. Specifically, the Part D benefit could dilute the incentive for potential Buy-In participants with Medicare coverage to enroll in the Buy-In program. Conversely, the complex set of choices posed by the Part D benefit may make it easier for dually enrolled Buy-In participants to obtain medications through Medicaid than through Medicare. Buy-In program personnel have done, and are planning to do, a great deal of outreach to inform dually eligible participants about their drug benefit options, and it will be important to closely monitor whether and how enrollment changes with respect to both size and composition in response to the Part D drug benefit.

One way to address these questions is to assemble individual-level data on earnings, Medicaid expenditures, and enrollment in the Buy-In and other public assistance programs. Combined, this information would be useful for identifying, for example, the relationship between earnings, disability status, and demographic characteristics. The ongoing effort of CMS to integrate data for Buy-In participants from several sources such as Medicaid, Medicare, and Social Security provides an important opportunity to gain insight into these and other issues that affect the Buy-In program in particular and people with disabilities overall.

Despite the value of standard indices of program performance, they may not capture all of the critical dimensions of employment related to Buy-In participants. Neither hours employed nor total earnings are adequate markers for the importance of work to individuals with disabilities. Therefore, a comprehensive understanding of the impact of the Medicaid Buy-In program will depend not only on analyses of quantitative measures of participation, but also on the insights of program administrators and participants themselves that can be gathered through survey data and process evaluations. Both federal and state authorities could collaborate in the design and implementation of such studies at the state level. In many states, interest in the Medicaid Buy-In program is high among state legislators and advocacy groups, and program administrators could address key questions through information gathered in well-designed descriptive or evaluative studies.

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# APPENDIX A

# CHARACTERISTICS OF STATE BUY-IN AND MEDICAID PROGRAMS, 2004

This appendix includes information on the Medicaid Buy-In program in all of the 28 study states. In addition to a summary of the key program characteristics in each state (Table A.1), we describe the programs in detail with regard to eligibility criteria, premium structure, other relevant policies, and recent experience in program implementation. When information in these areas was not available, or when it seemed otherwise appropriate, we combined these categories.

**Table A.1. Characteristics of State Buy-In and Medicaid Programs, 2004**

| Characteristics | Alaska | Arkansas | California |
|---|---|---|---|
| Implementation date[a] | July 1999 | February 2001 | April 2000 |
| Federal authority | BBA | Ticket Act Basic | BBA |
| Income eligibility | Earned income: Up to 250% FPL for Alaska[a] (includes spousal income)<br>Unearned income must be at or below $1,047 per month<br>Federal poverty guidelines for Alaska are higher than those for the 48 contiguous states | Up to 250% FPL net personal income (earned plus unearned, after disregards); unearned income must be less than SSI standard plus $20. Spousal income not counted. | Up to 250% FPL<br>(includes spousal income, excludes SSDI benefits) |
| Individual Resource limit | $2,000 | $4,000 | $2,000 |
| Medically needy income limit (monthly) | N/A | $108 | $620 |
| Income standard for poverty-level Medicaid (monthly) | N/A | N/A | $1,026 (includes a $230 disregard) |
| SSI Benefit (combined federal and state) (monthly) | $926<br>Alaska provides Medicaid coverage to people with disabilities receiving only the SSI supplement who have countable income up to $1,047 per month. | $564 | $790 |
| 1619(b) income threshold (monthly) | $3,422 | $1,799 | $2,420 |
| Premium threshold | 100% FPL | N/A | Net countable income of $1 |
| Premium structure | A sliding-scale premium as a fixed percentage of income. The maximum premium is 10 percent of net family income. | No premium required. Co-payments higher than those for regular Medicaid are required when income is above 100% FPL. | A sliding-scale premium is based on net countable income. For income from $1 up to 250% FPL, premiums range from $20 to $250 for an individual and $25 to $375 for a couple. |
| Income verification requirements | Eligibility is based entirely upon receipt of earned income, which includes spousal income. Not required to demonstrate that income and FICA taxes are being paid. | Required to demonstrate that earned income is reported to the IRS (see statement at comment DHS5) | Proof of employment (e.g., pay stubs or written verification from the employer). Self-employed or contractor provide records (e.g., W-2 forms, 1099 IRS form). Not required to demonstrate that income and FICA taxes are being paid. |
| Work stoppage protection | None | Up to six months given that participant states his/her intention to return to work | None |

[a]Program Characteristics are defined on page A-12.

| | Connecticut | Illinois | Indiana |
|---|---|---|---|
| Implementation date | October 2000 | January 2002 | July 2002 |
| Federal authority | Ticket Act Basic and Medical Improvement | Ticket Act Basic | Ticket Act Basic |
| Income eligibility | Up to $75,000 per year (excludes spousal income) | Up to 200% FPL (includes spousal income) | Up to 350% FPL (excludes spousal income) |
| Individual Resource limit | $10,000 | $10,000 | $2,000 |
| Medically needy income limit (monthly) | $477 | $283<br>Although Illinois had a medically needy income level of $283 in 2004, the disregard of income between $283 and the federal poverty level ($776 in 2004) gives the state, in effect, a medically needy income level of $776. | $564 |
| Income standard for poverty-level Medicaid (monthly) | N/A | $776 | N/A |
| SSI Benefit (combined federal and state) (monthly) | $747 | Individually budgeted | $564 |
| 1619(b) income threshold (monthly) | $3,533 | $2,137 | $2,362 |
| Premium threshold | 200% FPL | 100% FPL | 150% FPL |
| Premium structure | Premiums equal 10% of total income above 200% FPL | Premium payment categories are calculated based on the sum of 7.5% of unearned and 2% of earned income. | Based on percentage of applicant and spouse's gross income according to family size. |
| Income verification requirements | Must have payroll taxes, including FICA, taken out of wages, unless self-employed. If self-employed, must provide tax forms or legitimate business records. | Employment must be verified by pay stubs and employer documents that income is subject to income taxes and FICA. | Must have pay stubs and documentation that enrollee is paying income and FICA taxes. |
| Work stoppage protection | Enrollees may continue enrollment for up to 12 months if job loss due to (1) health crisis or (2) involuntary job dismissal and participant intends to return to work. The participant must continue to pay the monthly premium based on remaining income. | Up to 90 days if premiums are paid and a letter from a physician is submitted stating that the enrollee is unable to work due to health problems. | Enrollment can continue for up to 1 year after losing employment. |

| | Iowa | Kansas | Louisiana |
|---|---|---|---|
| Implementation date | March 2000 | July 2002 | January 2004 |
| Federal authority | BBA | Ticket Act Basic | Ticket Act Basic |
| Income eligibility | Up to 250% FPL (includes spousal income) | Up to 300% FPL (includes spousal income) | Up to 250% FPL (excludes spousal income) |
| Individual Resource limit | $12,000 | $15,000 | $25,000 |
| Medically needy income limit (monthly) | $483 | $475 | $100 |
| Income standard for poverty-level Medicaid (monthly) | N/A | N/A | N/A |
| SSI Benefit (combined federal and state) (monthly) | $564 | $564 | $564 |
| 1619(b) income threshold (monthly) | $1,891 | $2,278 | $1,876 |
| Premium threshold | 150% FPL | 100% FPL | 150% FPL |
| Premium structure | Based on sliding scale premium schedule with 11 premium brackets, ranging from $22 to $355 | Sixteen premium amounts based on income brackets from $55 to $152 for individual and $74 to $205 for two or more. Cannot exceed 7.5% of income. | $80 for 150%- 200%, $110 for 200%-250% FPL |
| Income verification requirements | Must have earned income verifiable by pay stubs, completed tax forms, or a signed statement from a person's place of work. Not required to demonstrate that income and FICA taxes are being paid. | Employment must be verifiable by pay stubs and employer documents that income is subject to FICA taxes. | Required to demonstrate that income and FICA taxes are being paid |
| Work stoppage protection | 6 months | 6 months | Individuals in the Buy-In who lose their jobs can retain their MPP eligibility for up to 6 months provided they intend to return to the workforce. |

| | Maine | Massachusetts | Michigan |
|---|---|---|---|
| Implementation date | August 1999 | July 1997 | January 2004 |
| Federal authority | BBA | 1115 Demonstration Waiver | Ticket Act Basic |
| Income eligibility | Up to 250% FPL on total income, up to 100% FPL on unearned income (includes spousal income) | No limit | No earned income limit. Unearned income limit is 100% FPL (excludes spousal income) |
| Individual Resource limit | $8,000 | No limit | $75,000 |
| Medically needy income limit (monthly) | $341 | N/A<br>Massachusetts is unique in that, rather than have a medically needy or spend down program as many other states do, all persons with disabilities who are not eligible for the working benefit plan of CommonHealth (i.e., the state's Buy-In program) are eligible for the non-working benefit plan, which requires that participants meet a one-time deductible to receive coverage. See Massachusetts' summary below for additional information. | $350 |
| Income standard for poverty-level Medicaid (monthly) | $831 (includes a $55 disregard) | $1,032<br>Massachusetts covers nonworking people with disabilities with incomes at or below 133 percent of the FPL through its Section 1115 demonstration waiver. | $776 |
| SSI Benefit (combined federal and state) (monthly) | $564 + $55 income disregard for state SSI supplement | $681 | $578 (Includes $564 federal and $14 state supplement) |
| 1619(b) income threshold (monthly) | $2,601 | $2,538 | $1,684 |
| Premium threshold | 150% FPL | 150% FPL | 250% FPL |
| Premium structure | $10 premium for 150%-200% FPL, $20 for 200%-250% FPL | Premiums based on two different sliding scales—one for enrollees with other health coverage, one for enrollees without it. Minimum premium of $9 for individuals with family income at or above 150% of the FPL. | Based on sliding scale ranging from $50 to $920 per month. |
| Income verification requirements | Must have earned income. Not required to demonstrate that income and FICA taxes are being paid. | Demonstrate at least 40 hours of work per month and that income taxes are being paid. | Must be employed on a regular and continuing basis. Not required to demonstrate the income or FICA taxes are being paid. |
| Work stoppage protection | None | Up to 3 months if the participant maintains premium payments. | Up to 24 months if the result of an involuntary layoff or determined to be medically necessary |

| | Minnesota | Missouri | Nebraska |
|---|---|---|---|
| Implementation date | July 1999 | July 2002 | July 1999 |
| Federal authority | BBA (prior to Oct 2000), Ticket Act Basic (as of Oct 2000) | Ticket Act Basic | BBA |
| Income eligibility | No upper income limit. Must have monthly wages or self-employment earnings of more than $65. (excludes spousal income) | Up to 250% FPL (excludes spousal income unless spouse's income is over $100,000) | Two-part income test: (1) sum of spouse's earned income and applicant's unearned income must be less than SSI standard ($564 in 2004); (2) countable income up to 250% FPL (includes spousal income) In Nebraska, the applicant's unearned income is disregarded if he or she is in an SSDI trial work period. |
| Individual Resource limit | $20,000 | $999.99 | $4,000 |
| Medically needy income limit (monthly) | $582 (75% of FPL) | $564 | $392 |
| Income standard for poverty-level Medicaid (monthly) | $776 (100% of FPL) | N/A | $776 |
| SSI Benefit (combined federal and state) (monthly) | $645 | $564 | $576 |
| 1619(b) income threshold (monthly) | $3,015 | $2,138 | $2,321 |
| Premium threshold | All enrollees must pay a minimum premium of $35. | 150% FPL | 200% FPL |
| Premium structure | Premiums based on a minimum of $35 or a sliding fee scale based on income and household size. The premium gradually increases to 7.5% of income for incomes equal to or above 300% of FPL. Must also pay 0.5 percent of unearned income. No maximum premium amount. | Four premium brackets: 151% to 175% FPL; 176% to 200% FPL; 201% to 225% FPL; and 226% to 250% FPL. Premiums are a percentage of income ranging from 4% for the lowest bracket to 7% for the highest bracket. | Sliding scale based on income ranging from 2% of income if income is from 200% to 210% of FPL to 10% of income if income is from 240% to 250% of FPL. |
| Income verification requirements | Average monthly earned income above $65. Medicare and Social Security taxes withheld or paid. | Must be employed. Not required to demonstrate that income and FICA taxes are being paid. | Must have earned income based on pay stubs, employer forms, or tax returns. Not required to demonstrate that income and FICA taxes are being paid. |
| Work stoppage protection | Up to 4 months if no earned income due to medical condition or involuntary job loss. | None | None |

| | New Hampshire | New Jersey | New Mexico |
|---|---|---|---|
| Implementation date | February 2002 | February 2000 | January 2001 |
| Federal authority | Ticket Act Basic | Ticket Act Basic | BBA |
| Income eligibility | Up to 450% FPL on earned income (includes spousal income) | Up to 250% FPL on earned income; up to 100% FPL on unearned income disregarding SSDI benefits (includes spousal income) | Up to 250% FPL on earned income, and up to $1,148/month on unearned income (includes spousal income). Must earn at least $900 per quarter. This state requirement is contrary to the BBA and Ticket statutes and CMS regulations. The work requirement is waived for SSDI recipients in the two-year waiting period for Medicare. |
| Individual Resource limit | $21,370 Participants who disenroll from the Buy-In program but remain enrolled in Medicaid have "asset continuity," allowing them to retain assets acquired during Buy-In enrollment in a separate bank account that is excluded from Medicaid eligibility requirements. | $20,000 | $10,000 |
| Medically needy income limit (monthly) | $578 | $367 | N/A |
| Income standard for poverty-level Medicaid (monthly) | N/A | $776 | N/A |
| SSI Benefit (combined federal and state) (monthly) | $591 | $595.25 | $579 |
| 1619(b) income threshold (monthly) | $3,293 | $2,252 | $2,119 |
| Premium threshold | 150% FPL | 150% FPL | Not applicable |
| Premium structure | Six brackets from $80 to $220 for individuals; individuals with gross income (spousal included) that exceeds $75,000 are required to pay premiums of 7.5% of the adjusted gross income | Flat rate<br>$25 individual<br>$50 couple<br>New Jersey does not collect premiums because the revenue would be insufficient to offset the administrative costs. | No premium required. Co-payments higher than those for regular Medicaid are required at all income levels; clients' responsibility to keep track of co-payments |
| Income verification requirements | Must be employed (proven with a pay stub or 1099 estimated tax statement if the individual is self-employed). Must also demonstrate that appropriate FICA contributions are being made. | Be employed full or part time. Not required to demonstrate that income and FICA taxes are being paid. | Proof that the applicant earned or expects to earn sufficient wages in calendar quarter to count toward Social Security coverage ($900 in a quarter in 2004). Not required to demonstrate that income and FICA taxes are being paid. |
| Work stoppage protection | 12 months | Up to 26 weeks if the person has worker's compensation or Temporary Disability Insurance and intends to return to work | None |

| | New York | North Dakota | Oregon |
|---|---|---|---|
| Implementation date | July 2003 | June 2004 | February 1999 |
| Federal authority | Ticket Act Basic and Medical Improvement | Ticket Act Basic | BBA |
| Income eligibility | Up to 250% FPL (includes spousal income) | Up to 225% FPL (excludes spousal income) | Up to 250% FPL on adjusted earned income (excludes spousal income) Participants must have minimum earnings of $900 per quarter. Oregon provides Medicaid coverage to individuals not receiving SSI but who have countable income below $565.70. |
| Individual Resource limit | $10,000 | $13,000 | $5,000 |
| Medically needy income limit (monthly) | $659 | $500 | N/A |
| Income standard for poverty-level Medicaid (monthly) | N/A | N/A | N/A |
| SSI Benefit (combined federal and state) (monthly) | $651 | $564 | $565.70 (includes a $1.70 state supplement)[b] |
| 1619(b) income threshold (monthly) | $2,879 | $2,514 | $1,920 |
| Premium threshold | 150% of FPL | All participants are required to pay a premium | After 6 months, income in excess of $2,200/month; Unearned income above the SSI level |
| Premium structure | 3% of net earned income plus 7.5% of net unearned income. Premiums not collected until automated premium collection and tracking processes are available. | 5% of gross income | "Cost share" equal to 100% of unearned income above SSI standard. Premium equal to gross income plus unearned income remaining after "cost share" is paid minus (1) mandatory taxes; (2) approved employment and independence expenses; and (3) 200 percent of FPL, and multiplying the remainder by 2% to 10%. |
| Income verification requirements | Must have earned income and demonstrate that income and FICA taxes are being paid. | May verify earned income with a letter from an employer or a pay stub. Not required to demonstrate that income or FICA taxes are being paid. | Must have at least $900 per quarter. Not required to demonstrate that income and FICA taxes are being paid. |
| Work stoppage protection | Up to 6 months in a 12-month period for medical reasons and involuntary job loss with intent of returning to work | Enrollees may continue enrollment if they experience a job loss due to health problems. | |

| | Pennsylvania | South Carolina | Utah |
|---|---|---|---|
| Implementation date | January 2002 | October 1998 | June 2001 |
| Federal authority | Ticket Act Basic and Medical Improvement | BBA | BBA |
| Income eligibility | Up to 250% FPL (includes spousal income) | Up to 250% FPL (includes spousal income), unearned income must be below SSI standard ($564 in 2004). Earnings must be greater than $810 (2004). This state-imposed requirement is contrary to the BBA and Ticket statutes and CMS regulations. | Up to 250% FPL (includes spousal income). |
| Individual Resource limit | $10,000 | $2,000 | $15,000 |
| Medically needy income limit (monthly) | $425 | N/A | $776 |
| Income standard for poverty-level Medicaid (monthly) | $776 | $776 | $776 |
| SSI Benefit (combined federal and state) (monthly) | $591.40 | $564 | $564 |
| 1619(b) income threshold (monthly) | $1,871 | $1,964 | $1,985 |
| Premium threshold | All participants pay a premium | N/A | 100% FPL |
| Premium structure | 5% of countable income. Premiums of less than $10 are waived. | Premium not required. | 15% of countable income |
| Income verification requirements | Must provide verification of earned income. Not required to demonstrate that income and FICA taxes are being paid. | Income verification required, FICA and income tax payment is not. | For wage employment, worker must demonstrate that FICA taxes are being paid. For self employment, worker must have a tax return or business plan. Not required to demonstrate that income and FICA taxes are being paid. |
| Work stoppage protection | May remain in program and have premium waived for up to 2 months if unable to work due to job loss or health problems. | None | None. |

| | Vermont | Washington State | West Virginia |
|---|---|---|---|
| Implementation date | January 2000 | January 2002 | May 2004 |
| Federal authority | BBA | Ticket Act Basic and Medical Improvement | Ticket Act Basic and Medical Improvement |
| Income eligibility | Two-part test for family income: 1) Income less than 250% FPL, 2) Income (after disregarding earnings and $500 of SSDI benefits) at or below the medically needy income threshold or SSI payment level (includes spousal income) | 220% FPL (includes spousal income) Only the participant's income is counted if spousal income is less than half of the SSI standard. | Up to 250% FPL, unearned income must be equal to or less than SSI benefit ($564 in 2004) plus $20 (excludes spousal income) |
| Individual Resource limit | $2,000<br>Disregards assets accumulated since enrollment | No limit | $2,000, $5,000 liquid asset exclusion |
| Medically needy income limit (monthly) | $800 | $571 | $200 |
| Income standard for poverty-level Medicaid (monthly) | N/A | N/A | N/A |
| SSI Benefit (combined federal and state) (monthly) | $631 | $570.90 | $564 |
| 1619(b) income threshold (monthly) | $2,332 | $1,762 | $1,916 |
| Premium threshold | N/A | $65 earned income | All enrollees must pay a minimum premium of $15 |
| Premium structure | Prior to June 2004, two premium brackets: 185-225% FPL ($50), 225-250% FPL ($60).<br>Premium eliminated in June 2004. | The lesser of (1) 7.5% total income or (2) a total of the following: 50% unearned income above MNIL plus 5% total unearned income plus 2.5% earned income after deducting $65 | Premiums are 3.5% of countable income with a $15 minimum amount. Enrollees must also pay an enrollment fee of $50, which includes the first month's premium. |
| Income verification requirements | Must have earned income. Not required to demonstrate that income and FICA taxes are being paid. | Must have payroll taxes taken out of wages, unless self-employed. If self-employed, must provide tax forms or legitimate business records | Must be employed and earning at least the minimum wage. Not required to demonstrate that income or FICA taxes are being paid. |
| Work stoppage protection | None | Enrollees may continue enrollment for up to 12 months if job loss due to (1) health crisis or (2) involuntary job dismissal and participant intends to return to work. The participant must continue to pay the monthly premium based on remaining income. | Participants may remain eligible for up to 6 months from the date of involuntary loss of employment if a written request for coverage is received within 30 days of the unemployment date, the participant continues to seek employment, and he or she continues to pay the required premium. |

| | Wisconsin |
|---|---|
| Implementation date | March 2000 |
| Federal authority | BBA |
| Income eligibility | Up to 250% FPL (includes spousal income) |
| Individual Resource limit | $15,000 |
| Medically needy income limit (monthly) | $592 |
| Income standard for poverty-level Medicaid (monthly) | N/A |
| SSI Benefit (combined federal and state) (monthly) | $683 |
| 1619(b) income threshold (monthly) | $2,304 |
| Premium threshold | 150% FPL |
| Premium structure | Equal to the sum of (1) 3% of an individual's earned income, and (2) 100% of unearned income minus certain needs and expenses and other disregards. If the second calculation is less than $25, this component of the premium is $0. |
| Income verification requirements | Required to either work or participate in an employment counseling program, which one can do for up to a year. Not required to demonstrate that income and FICA taxes are being paid. |
| Work stoppage protection | Work requirement may be waived for up to 6 months for health problems. Use of the grace period is limited to twice in a five-year period. May also enroll in health and employment counseling (HEC).<br>HEC allows for 9- to 12-month enrollment, either while initially searching for work or while looking for a new job after a job loss. A participant is eligible for two HEC applications in a five year period. |

[a]Definitions of program characteristics:

| | |
|---|---|
| Implementation date: | This indicates when the program began and is important because a program's enrollment growth may change as it matures. |
| Federal authority: | BBA = Balanced Budget Act of 1997; Ticket Act = Ticket to Work and Work Incentives Improvement Act of 1999. The federal authority denotes the set of regulations to which the state's Buy-In program must adhere. The BBA and the Ticket Act have somewhat different requirements. For instance, the BBA sets the income eligibility threshold at 250 percent of the FPL, and the Ticket Act allows states to establish their own income standards. |
| Income eligibility | This information describes how much income a program participant is allowed to have in each state. These criteria may influence Buy-In enrollment. Income eligibility is presented as a percentage of the federal poverty line (FPL). The table also indicates whether the state counts spousal income when determining Medicaid Buy-In eligibility.* |
| Resource limit | This is the maximum level of resources that a participant can accumulate and remain eligible for the Buy-In program. Similar to income eligibility, the resource limit may influence Buy-In enrollment. |
| Medically needy income limit | This is the maximum amount of income a person may have to be eligible for the medically needy or spend down program; one means for persons with disabilities to obtain Medicaid coverage. If a person's income is above this limit, he or she must spend down until his or her income is below it to become eligible for Medicaid through the medically needy program. A low medically needy income limit implies that it is more difficult for an individual to spend down and qualify for Medicaid, which may make the Buy-In program a relatively more attractive option. We present the monthly limit in 2004 for an unmarried person with disabilities |
| Income standard for other categorical Medicaid | This is the income threshold below which an individual with disabilities is categorically eligible for Medicaid. States that provide categorical coverage up to a high level may have a smaller pool of individuals who are eligible for the Buy-In program. We present the monthly income threshold in 2004 for an unmarried person with disabilities to qualify for categorical Medicaid eligibility (for example, the poverty-level option). |
| SSI benefit | SSI benefit (combined state and federal) is the total amount of cash benefits that an SSI recipient receives from the federal and state governments. The benefit level can have a major impact on Medicaid eligibility levels in states. A high benefit level expands mandatory Medicaid coverage to a larger number of individuals and, thus, makes the Buy-In program an option to a smaller number of workers with disabilities. Monthly combined federal and state SSI benefit in 2004 for an unmarried person with disabilities |
| 1619(b) income threshold | This is the ceiling for former SSI recipients to receive mandatory Medicaid coverage. Therefore, a high 1619(b) threshold provides Medicaid coverage to a larger number of people and should reduce the pool of Buy-In eligibles. Monthly income threshold for an unmarried person with disabilities in 2004 |
| Premium threshold | This is the countable income level above which Buy-In participants are required to pay a premium, and it is related to the number of people who pay a premium, which, in turn, relates to how costly the Buy-In program is for participants. |
| Cost-sharing policy | This determines who pays a premium, how much each participant pays, and how premiums are graded across different income brackets, all of which shape enrollment patterns. |
| Income verification requirements | This describes the procedures for verifying participants' income. Because states cannot define work or require participants to work a minimum number of hours, income verification requirements are one way to influence the employment practices of its Buy-In enrollees. |
| Work stoppage protection | These provisions allow a person with disabilities to remain enrolled in the Buy-In program without earnings. The presence of a grace period may minimize the cycling of participants on and off of the program and also may influence the earning patterns of program participants. |

# ALASKA

**Overview.** The Working Disabled Medicaid Buy-In program was implemented in July 1999 under the authority of the BBA. Enrollment has increased steadily since the program's inception, reaching 192 enrollees as of December 2003 and leveling off thereafter. Although nominal enrollment in the Working Disabled Medicaid Buy-In program is low relative to other states, it is substantially higher than the Alaska Department of Health and Human Services originally predicted. Furthermore, Alaska's Buy-In program ranks near the median relative to other programs in terms of enrollment per 100,000 state working age residents.

Alaska's Buy-In program is one component of a broader initiative called Alaska Works that is designed to "address the major barriers keeping people with disabilities who receive public support from working" (Folkemer et al. 2002, Health and Social Services, State of Alaska 2004).

**Eligibility Criteria and Program Context.** To be eligible for Alaska's Buy-In program, disabled adults must (1) be ineligible for Alaska's state SSI supplement (Adult Public Assistance or APA), which is accompanied by Medicaid coverage; and (2) pass both a net family income test and an unearned income test. The family income test requires that the net countable income of each family member be below 250 percent of the FPL for Alaska.[1] The unearned income test requires that the individual's unearned income be at or below the income standard for the Adult Public Assistance program ($1,047 in 2004). In addition, an individual may accumulate up to $2,000 in resources.

Alaska's combined federal and state SSI supplement of $926 is by far the largest among states with Buy-In programs. Alaska elected the standard of need option that provides Medicaid coverage for all individuals with income at or below $1,047 ($78 above 100 percent of the FPL for Alaska). Alaska does not require that the Buy-In participant actually work, only that earned income from the participant or spouse has rendered the recipient ineligible for SSI or Adult Public Assistance. If a Buy-In participant and his/her spouse do not have earnings because the participant is unable to work due to factors such as health problems or involuntary loss of employment, the state will re-evaluate that participant's eligibility for Adult Public Assistance and Medicaid.

**Premium Structure.** Most Buy-In participants—65 percent of those enrolled in the fourth quarter of 2004—paid premiums that averaged $35. Premiums are required for enrollees with incomes above 100 percent FPL and are calculated along a sliding fee scale as a fixed percentage of the participant's income. The maximum premium amount is 10 percent of net family income.

[1]Federal poverty line guidelines for Alaska are higher than those for the 48 contiguous states.

# ARKANSAS

Medicaid for the Working Disabled (WD) was implemented in Arkansas on February 1, 2001. According to state personnel, the work group that established the program's eligibility criteria intended to target two groups of individuals: (1) SSI beneficiaries who wanted to work but were afraid of losing their benefits and (2) employed workers with disabilities who were uninsured or lacked adequate health coverage. In the early stage of the program, enrollment rose at a rate that far exceeded the state's projections, with the largest increase—from 56 to 170 individuals—occurring in the second month of the program. To restrict growth, two eligibility criteria were added in September 2001: an unearned income limit and an IRS documentation requirement. The effects of these new requirements emerged not immediately but during the annual re-certification process, when many people were terminated from the program. As of June 2005, the program had 45 enrollees, down from a high of 188 in September 2001.

**Eligibility Criteria and Program Context.** The eligibility criteria for Arkansas's WD program were originally moderately restrictive compared with the criteria in other states. However, with the addition of the new requirements in September 2001, the program has become one of the most restrictive in the nation in terms of eligibility. In addition, Arkansas does not have a categorical Medicaid option, and their medically needy coverage requires single people to spend down to $108. Using the SSI methodology, Arkansas counts individual net personal income and unearned income separately: a net personal income threshold of 250 percent FPL and an unearned income limit of SSI level, or $579. The net income limit increases according to family size. The asset limit in Arkansas, $4,000 for an individual and $6000 for a couple, increases by increments of $200 with each additional child living in the home. Countable resources do not include any type of retirement account. Arkansas also has "approved accounts," which can be set up by participants to divert funds for the purpose of "enhanc[ing] independence and increas[ing] employment opportunities" (AR Medical Services Policy Manual 2001). These accounts have a $10,000 sheltered limit; excess monies count toward the buy-in resource threshold. In addition, all participants must report income to the IRS and provide verification.

**Premium Structure.** Although Arkansas does not charge a premium, it does require a co-payment for some WD Medicaid recipients. Individuals with countable income below 100 percent FPL are subject to the usual Medicaid coinsurance amount in state, which equals 10 percent of the first day of a Medicaid-covered hospital stay and co-payments of $0.50 to $3 for every prescription. Recipients earning more than 100 percent FPL are assessed an amount for physician visits and prescription drugs: $10 per visit, $10 generic/$15 brand name prescription drugs, and 25 percent of the first day of the Medicaid per diem rate. Arkansas reported an average co-payment of $22 for participants in the fourth quarter of calendar year 2004.

**Other Policies.** Arkansas has a six-month grace period to protect the buy-in status of enrollees in the event of an involuntary, temporary job loss.

**Program Experience.** The program experience to date suggests that the two new rules meant to limit enrollment—submitting IRS documentation and an unearned income limit—acted as intended. The largest drop in enrollment, 39 percent, occurred in 2002, when the number of enrollees decreased from 159 enrollees in February to 97 enrollees in March. State personnel cite the change in eligibility requirements as the cause of enrollment decline. Enrollment in Arkansas's Buy-In program has not recovered since. The average monthly earnings for enrollees with reported earnings in the state's Unemployment Insurance system is $1,014, which is quite high compared to the average of $766 across all 28 Buy-In states. Arkansas noted that the unearned income limit and strict IRS verification requirements may be either promoting higher earnings or weeding those with low earnings out of the program.

Another factor limiting Buy-In enrollment was a lack of outreach during the program's early years as the state weathered a budget crisis. At the time of this writing, the state was preparing to launch a statewide outreach campaign funded by their Medicaid Infrastructure Grant.

## CALIFORNIA

**Overview.** The Medi-Cal Working Disabled Program (WD) was launched in April 2000 under the authority of the Balanced Budget Act of 1997. Enrollment in WD (1,165 individuals as of December 31, 2004), while lower than many other states despite California's large population, has increased steadily since the program's inception. At least two factors affect California's enrollment level: (1) unintended enrollment disincentives due to high income thresholds in other Medicaid eligibility categories and (2) a low asset limit.

**Eligibility Criteria and Program Context.** Compared with other states, California has a high combined federal and state SSI supplemental benefit ($790 per month in 2004). It also has a high income threshold ($620 for an individual) for the Medically Needy program, which means that individuals in this program can have higher earnings (after medical bills are taken into account) than in other states and still have access to Medicaid. The presence of other pathways to Medicaid may, in effect, be competing with WD for enrollment and thus limit its size.

The WD asset limit of $2,000 for an individual ($3,000 for couples) is lower than many other states' Buy-In programs. WD has a typical income eligibility limit of 250% of FPL, but it is one of only a few programs that exempt SSDI benefits when calculating countable income, which should allow more SSDI recipients to enroll.

**Premium Structure.** WD charges premiums ranging from $20 to $250 per month for an individual and $30 to $375 per month for couples. The premium is determined by a

sliding scale based on income, and all enrollees must pay a premium. This premium structure may act as an enrollment disincentive, because (1) for participants with incomes close to 250 percent of the FPL, the premiums may appear to be unaffordable, and (2) the medically needy program offers an attractive alternative pathway to Medicaid for those who have fewer health care needs.[2] Individuals who do not pay their premium can remain on the program for up to two months before being disenrolled.

**Program Experience.** In response to a report indicating a lack of awareness about the program among potential participants and intake workers who staff Medicaid and other benefit program offices (Jee and Menges 2003), the state began broad outreach efforts in 2004 through its Medicaid Infrastructure Grant. The state created and distributed brochures about the WD program and employment and support services available to persons with disabilities. In addition, local planning committees sponsored training sessions regarding various work incentives, including WD. State personnel noted that these outreach efforts contributed to the higher enrollment growth rate in 2004 compared to the previous year (36 percent growth in 2004 versus 27 percent in 2003). Furthermore, there was greater enrollment growth in local areas where outreach has been more intensive.

## CONNECTICUT

**Overview.** Connecticut's Medicaid for the Employed Disabled program, enacted in October 2000 under the authority of the Ticket Act of 1999, was designed as a work incentive program to allow disabled individuals to retain Medicaid coverage as their earnings from work increased. This state was the first to establish a Buy-In program offering both the Basic Insurance Group and the Medical Improvement Group; the first two participants enrolled in the latter in 2004. Enrollment in the Medicaid for the Employed Disabled program grew quickly early on, reaching 1,600 enrollees after its first year. Participation in the program has since increased to 3,365 as of December 2004, making it the eighth largest Buy-In program.

**Eligibility Criteria and Program Context.** The Medicaid for the Employed Disabled program has a relatively high income eligibility threshold of $75,000, and its resource (asset) limit of $10,000 is equal to median among Buy-In programs. Connecticut is one of the only states to vary its state SSI supplement amount based on an individual's financial resources; the maximum combined federal and state SSI income benefit was $747 per month in 2004, the third highest among the 28 Buy-In programs with a Medicaid Infrastructure Grant. Connecticut is among those states that have chosen to use eligibility criteria that are different from SSI [that is, the 209(b) option], which enabled Connecticut's Spend-Down program to

[2]With medically needy program, they only share cost in months when they have received a service, instead of paying a monthly premium.

have a lower asset limit than SSI sets for Medicaid eligibility—$1,600 for individuals and $2,400 for couples compared to the SSI limits of $2,000 and $3,000 respectively.

Connecticut also has a high 1619(b) income threshold ($3,533 per month) among states with Buy-In programs. However, compared to other Buy-In states with Medically Needy programs, Connecticut has a low Medically Needy protected income level ($477 per month in 2004), which might make its Buy-In program more attractive as a pathway to Medicaid than spending down below this level.

**Premium Structure.** Buy-In participants in Connecticut are required to pay premiums equal to 10 percent of their income in excess of 200 percent of the FPL. Program participants with income less than 200 percent of the FPL, or 88 percent of participants in 2004, pay no premium at all. An individual's premium is reduced by the amount paid out-of-pocket for medical insurance premium payments. The individual's net premium obligation may not exceed 7.5 percent of net countable income.

**Other Policies.** Participants in the Medicaid for the Employed Disabled are required to work for pay and to make appropriate FICA contributions, either through payroll deductions or as self-employed individuals. Buy-In enrollment can continue for one year after the loss of employment due to health problems or involuntary dismissal if the person either plans to return to employment when the health problems end or is seeking new employment.

## ILLINOIS

**Overview.** Illinois implemented its Health Benefits for Workers with Disabilities (HBWD) program in January 2002 under the authority of the Ticket Act of 1999. According to HBWD personnel, the program was designed primarily as a work incentive for individuals with disabilities because the disability community insisted that participants needed "real" work experience in order to promote higher earnings. Enrollment in the HBWD program has increased modestly since its inception, reaching 656 in December 2004. This level of enrollment was significantly lower than the 3,200 participants that were projected to enroll by the end of 2002. Potential reasons behind this shortfall may include a low income threshold for the Buy-In program, a separate Buy-In application process from general Medicaid, and the HBWD premium requirement (see below for more detail).

**Eligibility Criteria and Program Context.** The HBWD program is available to persons with disabilities with incomes less than 200 percent of the FPL and resources less than $10,000. The HBWD income threshold, which is low relative to other Buy-In states, may constrain enrollment in the HBWD program because the allowable income spans a narrow range—from 100 percent to 200 percent of the FPL. Other potential reasons for lower enrollment than the state originally expected include the following:

- The HBWD program requires applicants to verify that they are paying the applicable income and FICA taxes on all earned income (including self-employment income), which is stricter than in some other Buy-In states.

- The HBWD program has a separate application process for eligibility determination from the process used for traditional Medicaid. Many other states allow individuals to complete Buy-In applications at local Medicaid offices, and some have provided Buy-In intake as part of an automatic enrollment process. The Illinois Buy-In, however, is identified primarily as a work incentive program, not as an extension of, or alternative to, regular Medicaid.

- Some potential HBWD enrollees may find it financially advantageous to remain in the spend-down program rather than enroll in HBWD for two reasons. First, individuals may not have to pay for all medical costs incurred while meeting the spend-down limit, which is also the case in many other states with medically needy programs. As a result, out-of-pocket expenses for individuals in the medically needy program may be less than the premium for some individuals in the HBWD program. Second, an HBWD participant is required to pay a premium each month, whereas a person eligible for Medicaid under the spend-down option only needs to meet the spend-down criteria when the person wants Medicaid to cover medical costs for a particular month.

Illinois has a low medically needy income threshold ($283 per month) relative to other states, but state officials noted that the medically needy income threshold is essentially equal to 100 percent of the FPL because income between $283 and 100 percent of the FPL is disregarded. In addition, the state has a 1619(b) threshold of $2,137, which is close to the median among states with a Buy-In program. Illinois provides a supplement to the federal SSI benefit, and it is one of two states with a Buy-In program that varies its state SSI supplement amount based on an individual's financial resources (Connecticut is the other).

**Premium Structure.** Premium categories are calculated based on a premium grid that includes earned and unearned income parameters. Generally premiums are based on about 2 percent of earned and 7.5 percent of unearned income. Ninety-nine percent of HBWD participants were required to pay monthly premiums in 2004 that averaged $51.

**Other Policies.** If an HBWD participant is unable to work due to medical reasons, he or she may remain in the program for up to 90 days before being disenrolled, provided premiums are paid. However, if a participant stops working due to a non-medical reason and is not employed within 30 days, then the individual's enrollment is discontinued.

**Program Experience.** HBWD personnel believe that the program has made strong outreach efforts. Early on, staff mailed out 4,000 brochures to potential applicants, but they indicated that the outcome of this effort was disappointing. HBWD staff have worked with mental health centers, county and private hospitals, the Department of Human Services,

Vocational Rehabilitation counselors, eligibility counselors, and local Medicaid offices to spread information about the program.

## INDIANA

**Overview.** Indiana implemented its Medicaid for Employees with Disabilities (M.E.D. Works) program in July of 2002 under the Ticket Act of 1999. Enrollment in the program got off to a quick start, reaching 1,553 enrollees within three months of the program's inception and 6,117 participants by December of 2004.

Program enrollment has been substantially higher than originally expected, primarily because of the high enrollment of developmentally disabled individuals, many of whom perform minimal work in sheltered workshops. After showing positive earnings, these individuals are typically transferred into the M.E.D. Works program. Beginning in October 2005, the first $65 of an individual's earned income is disregarded. Therefore, an individual must earn at least $65 per month to quality for the program.

**Eligibility Criteria and Program Context.** Disabled individuals in Indiana who are employed and have countable incomes below 350 percent of the FPL are eligible for the M.E.D. Works program. This income limit is high relative to other state Buy-In programs. Although the resource limit of $2,000 is low among Buy-In programs, the state does exclude up to $20,000 of resources in an Independence and Self-Sufficiency Account—these funds are designed to improve employability and independence. The use of such an account has to be approved by the program, and very few participants (i.e. fewer than 15, according to state officials) have one. The maximum allowable income level for Indiana's Spend-Down program is identical to the federal SSI benefit of $564. Indiana's 1619(b) income threshold $2,362 per month is slightly above the median of $2,265 among states with Buy-In programs. SSI recipients in Indiana are not automatically eligible for Medicaid, because the state chose Medicaid eligibility criteria that are more restrictive than those for SSI eligibility through the 209(b) option: the Buy-In program's resources limit is $1,500 for an individual versus the $2,000 SSI limit. The income eligibility threshold for both the SSI and Medicaid programs in 2004 was $564.

**Premium Structure.** The premium amount M.E.D. Works participants pay is based on their income bracket. Individuals with income below 150% of FPL do not pay premiums. The premium ranges from $48 for those participants with incomes from 150-175 percent of the FPL to $161 for those with incomes from 300-350 percent of the FPL. Twenty-eight percent of M.E.D. Works participants who were enrolled for the entire fourth quarter of 2004 paid premiums, which averaged $74.

**Other Policies.** A Buy-In enrollee is able to remain in the program for up to 12 months after losing employment for involuntary reasons if he or she (1) requests in writing that Buy-In coverage continue; (2) continues to meet the eligibility requirements described above; and (3) maintains a connection to the workforce (for example, workforce

development). The amount an individual pays for private health coverage is deducted from their premium amount.

**Program Experience.** About 8 in 10 (79%) of Buy-In participants who enrolled for the first time in 2004 were in Medicaid for at least 1 month during the year prior to enrollment. The fact that most enrollees are transferring from one Medicaid eligibility category to another suggests that the M.E.D. Works program is functioning primarily as a work incentive for current Medicaid beneficiaries rather than providing Medicaid coverage among disabled individuals without Medicaid coverage. However, the state's earnings minimum as of October 2005 was implemented to promote a more substantial work effort.

The Family and Social Services Administration, which administers Indiana's M.E.D. Works program, is conducting activities to disseminate information about the program. These activities include developing materials such as fliers, brochures, and fact sheets containing program information, and developing and conducting training sessions.

## IOWA

**Overview.** Iowa's Buy-In program, Medicaid for Employed People with Disabilities (MEPD), was launched in March 2000 under the authority of the Balanced Budget Act of 1997. The Iowa business community led efforts to pass the state's legislation, which was framed and marketed as a work incentive rather than a health insurance expansion (Folkemer et al. 2002). The state estimated that 700 individuals would enroll in the program by June 2002 (Folkemer et al. 2002), whereas actual enrollment reached 4,092 by that date. As of December 2004, there were 7,695 enrollees, making it the third largest Buy-In program. The broader environment of employment supports for persons with disabilities, as well as several design and implementation features of the Buy-In program, may have contributed to the steady enrollment growth.

**Eligibility Criteria and Program Context.** Participants in the MEPD program must be under the age of 65, meet the SSI definition of disability, and have earned income from employment or self-employment, verified through pay stubs, tax forms, or signed statement from a person's employer.

A high rate of employment among SSI beneficiaries may indicate an overall environment in Iowa that supports employment of individuals with disabilities (Social Security Administration 2005). Thus, people with disabilities in Iowa may be more likely to obtain and keep a job, and find the MEPD program useful for maintaining appropriate health insurance coverage. In addition, the state's spend-down level for the medically needy program is low compared to other states, making it more difficult for individuals to qualify for basic Medicaid, and hence potentially more likely to enroll in the MEPD program.

**Premium Structure.** Individuals must pay a monthly premium based on gross income according to a sliding scale premium schedule with 16 premium brackets ranging from $22

to $355. If an individual's gross income (including spousal income) is below 150 percent of the FPL, then no premium is required. Only 25 percent of participants were required to pay a premium in 2004, and the average monthly premium of those who paid a premium was $39.

**Other Policies.** A program participant who loses a job can remain in the program for up to six months if the participant shows the intention to return to work. Personal assistance services are only available to program participants if they qualify for waiver services.

**Program Experience.** Iowa has not performed specific outreach activities targeted to the Buy-In program since 2001, although the state has hosted a national conference on partnering with industry to employ people with disabilities. According to Iowa MEPD staff, information about the program has spread primarily through word of mouth.

## KANSAS

**Overview.** Working Healthy, the Kansas Medicaid Buy-In program, was implemented in July 2002 to encourage persons with disabilities to seek work and earn more without endangering their health insurance coverage (Hall and Fox 2002). Enrollment in the program has continued to grow since inception and has exceeded initial projections.

**Eligibility Criteria and Program Context.** To qualify for Working Healthy, a person must (1) have a disability determined by Social Security, (2) be at least 16 years of age but no older than 64, (3) have total household income less than 300 percent of the FPL, (4) not be receiving Home and Community Based Services (HCBS) or living in a nursing facility, and (5) have resources that are less than $15,000. Kansas added a Medically Improved Group in February 2005, which will allow individuals to remain on their program if (1) their disability improves to the point where it is no longer considered a disability; and (2) they work at least 40 hours per month while earning at least the federal minimum wage.

Many program features of the Working Healthy program should make it attractive to eligible persons and facilitate high enrollment. First, the medically needy income limit is low ($475 per month) compared to many other Buy-In states with a medically needy program, which makes it harder for participants to spend down to the necessary level and thus makes the Buy-In program look more desirable by comparison. Second, Kansas has no state supplementation to its SSI cash benefit. The low SSI benefit may encourage individuals to seek work under the Buy-In program to increase their income. Third, the resource limit of $15,000 is relatively generous compared to other Buy-In states among which the median resource limit is $10,000. Fourth, the state has been active in reaching out to potential and current participants and other stakeholders. These factors suggest that enrollment in the program could continue to increase over time. Offsetting these features, however, is the lack of availability of personal assistance services for Buy-In enrollees. Kansas is applying for an 1115 waiver to provide these services in the future.

**Premium Structure.** Participants are charged a monthly premium if adjusted net income is over 100 percent of the FPL. The program has a sliding fee scale based on income. There are sixteen premium levels for single participants that range from $55 to $152 and from $74 to $205 for two or more people. The premium cannot exceed 7.5 percent of the participant's income.

**Other Policies.** Currently, Working Healthy does not have personal care services available to program participants, although the state is working to secure an 1115 waiver to offer these services. Work requirements in the state are fairly stringent. Employment must be verifiable by pay stubs and employer documents that prove income is subject to an income test and FICA contributions. A person who loses a job may remain in the program for up to six months.

**Program Experience.** According to a study by Kansas University, the majority of Working Healthy participants (52 percent) in November 2002 had a mental illness (Hall and Fox 2003). The program currently does not cover expenses for personal assistance services, which might make the program more attractive for other types of persons with disabilities, such as those with physical disabilities. A survey conducted by the same group in June 2003 indicated that, for participants for whom information about job types was known, two-thirds held jobs within the service or maintenance sector, and more than half worked 19 hours per week or less (Hall 2003). The most common reason cited by disenrollees for leaving the program was the loss of a job, and consequently being deemed ineligible for the program (Hall 2003).

Working Healthy is administered through the Kansas Department of Social and Rehabilitation Services. The program office has sponsored a number of outreach activities, including orientations for providers and benefit specialists and conferences targeted to various stakeholders. An advisory council meets on a quarterly basis to provide knowledge and expertise to program staff.

## LOUISIANA

Louisiana implemented the Medicaid Purchase Plan for Workers with Disabilities (MPP) in January 2004 under the Ticket Act of 1999. Viewed by the state as a work support program, the MPP targets any person with a disability who works. Due primarily to a push from the advocacy community, the MPP was passed very quickly and without controversy. Although the program was developed independently, the Advisory Council considered state fiscal issues in the initial structuring of the program. In order to gain more political support and increase its chance of passage, the introduction of the MPP to the Legislature was delayed until the second year of the MIG. Within three months of its inception, the program had 64 enrollees, and as of June 2005, enrollment rose to 522, which is in line with state expectations. Net program growth has been 30 to 40 enrollees per month, which state personnel attribute to outreach activities, including MIG-sponsored job fairs for people with disabilities.

**Eligibility Criteria and Program Context.** The eligibility criteria for other pathways to Medicaid are restrictive relative to other states. Louisiana provides only limited categorical Medicaid eligibility to SSI/former SSI recipients and individuals in nursing facilities or waiver programs. The state's Medically Needy income threshold is also low relative to other states ($100 per month). It is therefore not surprising that only 4 in 10 (42 percent) of first-time MPP enrollees in 2004 had Medicaid coverage in the preceding year, compared to 65 percent across all 28 states covered in this report. Based on individual earnings, Louisiana has a countable income threshold of 250 percent of the FPL. There is no separate unearned income limit. The asset limit is $25,000, exclusive of retirement accounts, life insurance polices, medical savings accounts, and spousal property. In addition, Louisiana requires individuals to pay all applicable income and FICA taxes on their reported earnings regardless of whether they are ultimately below the taxable level.

**Premium Structure.** Any enrollee with countable income over 150 percent FPL must pay a premium. The structure in Louisiana has two-tiers: 150-200 percent FPL and 200-250 percent FPL, requiring a monthly payment of $80 and $110 respectively. In calendar year 2004, only 34 enrollees, or 6.5 percent of all MPP enrollees, paid a premium, implying that 93.5 percent of enrollees had countable income of less than 150 percent FPL per month. Louisiana reports that the reason it chose 150 percent FPL as the threshold, which is higher than the 1619(b) threshold, was to give individuals in the 1619(a) and 1619(b) categories an incentive to enroll in the Buy-In program.

**Other Policies.** Individuals in the Buy-In program who lose their job remain eligible for the MPP for up to 6 months provided that they intend to return to the workforce. Louisiana also reimburses a number of individuals with group health insurance for the cost of this coverage.

**Program Experience.** Louisiana's outreach activities include job fairs for people with disabilities. In 2004, the state held eight such fairs and connected about 2,000 job seekers with more than 135 businesses. Nine job fairs are planned for in 2005.

## MAINE

**Overview.** The MaineCare Workers with Disabilities (WWD) Option started in 1999 to allow persons with disabilities work more without losing their Medicaid benefits. Since implementation of the program in August 1999, program enrollment rose steadily to a high of 775 participants in September 2002. By June 2003, enrollment had dropped by nearly a third, probably because the state's eligibility system was malfunctioning and redetermination had to be done manually.[3] Since then, however, program enrollment has risen gradually to

[3]According to state officials, the manual eligibility redetermination process caused a reduction in enrollment because caseworkers found that some WWD enrollees were ineligible for the program.

644 in December 2004. Low enrollment in the WWD program may be the result of many contributing factors, including a separate income limit for unearned income, a high income limit for the Poverty Level option to Medicaid, a limited pool of medically needy enrollees to draw from, and no work protections in case of job loss.

**Eligibility Criteria and Program Context.** To be eligible for the WWD program, participants must have earned income and meet a two-step income test. First, countable unearned income must be equal to or less than 100 percent of the FPL. Second, total countable earned and unearned income must be less than 250 percent of the FPL. According to a WWD official, the unearned income limit was established in lieu of a work requirement as a mechanism to control program growth by limiting enrollment to SSDI beneficiaries with low unearned income. The asset limit for program participants (which excludes certain items, such as home, car, and some savings) is $8,000 for an individual.

Two elements of the context of WWD in Maine should promote enrollment. Compared to other states, Maine has a low medically needy income level ($341 per month) and a low combined federal and state SSI payment ($564 plus a $55 income disregard), so persons with disabilities may be less likely than their counterparts in other states to obtain Medicaid through these pathways. However, the relatively high income threshold for categorical Medicaid eligibility ($831 per month) makes this Medicaid pathway attractive and thus may limit enrollment in the Buy-In program.

**Premium Structure.** The premium amount is based on countable monthly income projected for a six-month eligibility period. Individuals with monthly countable income under 150 percent of the FPL or those individuals paying a Medicare Part B premium pay no premium for the Buy-In program. If monthly countable income is between 150 percent and 200 percent of the FPL, the monthly premium is $10. Individuals with income over 200 percent of the FPL have a $20 premium. Only 6 percent of program participants were required to pay a premium in 2004, and the average premium for these individuals was $13 per month, a relatively modest sum compared to other states.

**Other Policies.** Participants who suffer a job loss may be disenrolled from the program and possibly transferred to a Medicaid eligibility group without a premium (Folkemer et al. 2002).

**Program Experience.** The WWD program has an advisory group—represented by state and federal government officials, consumer and advocacy groups, and service providers—that meets on a quarterly basis. The program established the Continuing Health Options and Incentives via Coordinated Employment Supports, or CHOICES, sponsored by the Muskie School of Public Service at the University of Southern Maine, to better inform the program through surveys and other research. The state's primary outreach activities in 2004 involved updating brochures and maintaining a web site with program information.

# MASSACHUSETTS

**Overview.** CommonHealth, a benefit plan within Massachusetts' Medicaid program (MassHealth) for individuals with disabilities, was originally established as a state-funded plan to provide medical assistance to the working disabled and was integrated into an 1115 waiver on July 1, 1997. Massachusetts' Buy-In program is the oldest in the nation. Observers of the Buy-In program in Massachusetts have commented on the surprising growth in the number of participants given the alternative Medicaid coverage options offered by the state to working individuals with disabilities—as of December 2004, the CommonHealth program had 7,520 enrollees, making it the fourth largest Buy-In program in the nation.[4]

**Eligibility Criteria and Program Context.** The program has no income or asset limits, but participants must work 40 hours per month to obtain and maintain Buy-In eligibility.[5] The context of Massachusetts' Buy-In program is characterized by generous eligibility criteria relative to other states with Buy-In programs. Massachusetts provides Medicaid coverage to persons with disabilities with incomes below $995 per month (128 percent of the FPL). The standard combined federal and state SSI benefit of $681 is higher than most other Buy-In states, suggesting that relative to their counterparts in other states, workers with disabilities in Massachusetts could have relatively high SSI benefits and still maintain the basic Medicaid coverage. Similarly, only six other states with Buy-In programs exceed Massachusetts' 1619(b) threshold of $2,538, suggesting that workers with disabilities in this state who have higher incomes than most other Buy-In states and still maintain eligibility for Medicaid through the SSI program. Furthermore, all disabled individuals who work less than 40 hours per month are eligible for the non-working benefit plan of CommonHealth. The non-working benefit plan of CommonHealth is different from a traditional medically needy or spend-down program because participants only need to meet a one-time deductible rather than continue to meet the monthly spend-down requirement (Fishman and Cooper 2002). Therefore, workers with disabilities who do not qualify for SSI can obtain Medicaid coverage regardless of their income and/or asset levels.

**Premium Structure.** Premiums are established based on one of two sliding scales—one scale for those with other health insurance, and one for those without it. There is a minimum premium of $9 per month for enrollees with incomes at or above 150 percent of the FPL. In March 2003, the state modified its sliding fee scale to cause premiums to

[4]Fishman and Cooper (2002), for example, write "Notably, Medicaid buy-in enrollment has grown strongly even with attractive alternative eligibility pathways to Medicaid and buy-in requirements that together strictly limit the buy-in to the work incentives population."

[5]Enrollees may also be eligible by working an average of 40 hours per month over 6 months. The BBA and Ticket Act do not allow setting limits on hours worked, but Massachusetts was able to do so under the 1115 waiver.

increase more rapidly as income rises. The state also implemented administrative procedures, such as payment plans, to avoid disenrollment due to financial hardship. Approximately 9 in 10 (91 percent) Buy-In enrollees in Massachusetts paid an average monthly premium of $47 in 2004.

**Program Experience.** Overall, the presence of other pathways to Medicaid for the disabled in Massachusetts, along with the Buy-In program's explicit criterion for steady work, would suggest that the eligible population in this state would be limited. However, Massachusetts has implemented a variety of strategies to inform people about the Buy-In and to address the concern among adults with disabilities that beginning or returning to work inevitably means losing publicly funded health insurance. In addition, the absence of asset and income limits in the Buy-In program may promote employment.

In 2004, Massachusetts continued to see an increase in the percentage of people with disabilities enrolled in the CommonHealth program relative to other Massachusetts Medicaid programs. In 2005, Massachusetts launched a new set of outreach activities which integrate information about CommonHealth, other work incentive programs, and employment services using peer education and other strategies with consumers and direct service providers.

## MICHIGAN

Michigan's Freedom to Work program was implemented on January 1, 2004, under the Ticket Act of 1999. There are 370 individuals now enrolled in the program. The state commissioned an evaluation of the program's effectiveness, and in January 2006, the governor and the state legislature are expecting a report on program enrollment, possibilities for program expansion, and findings from a cost-benefit analysis.

**Eligibility Criteria and Program Context.** Michigan has both a poverty level Medicaid category and a Medicaid spend-down program in which the range of protected income is $341 to $408. The eligibility criteria for Freedom to Work are unique in that some of the requirements are generous compared to most states, including an unlimited earned income level and an asset limit of $75,000. Despite these liberal components, the overall program is restrictive because of two other significant criteria: first, the unearned income limit of 100 percent FPL, and second, the requirement that an individual must be enrolled in another Medicaid eligibility category, excluding the spend-down program, in the month prior to Buy-In enrollment.[6] These eligibility requirements may have limited Freedom to Work/Medicaid Buy-in enrollment.

[6] This state-imposed requirement is contrary to the statutes and CMS regulations.

**Premium Structure.** Freedom to Work has a four-tiered premium structure based on an earnings range defined by the FPL. Individuals with net countable income less than 250 percent of the FPL are not required to pay a premium; participants with net countable income from 250 to 350 percent of the FPL pay a $50 monthly premium; those with net countable income from 350 to 500 percent of the FPL pay a $190 monthly premium; those with net countable income from 500 to 800 percent of the FPL pay $460 monthly; and those earning $75,000 or more per year pay $920 per month. Failure to pay in a timely manner will result in a "lock-out" or ineligibility for the program. In 2004, none of the 125 first-time enrollees were required to pay a premium.

**Other Policies.** Buy-In participants are allowed involuntary temporary breaks in employment, or a "grace period," of up to 24 months. According to the state, a number of individuals with private insurance are reimbursed for the cost of this coverage, which may explain the comparatively high rate of enrollees (12 percent) who have both Medicaid and private insurance.

**Program Experience.** Of the 125 first-time Freedom to Work enrollees, 91 percent were receiving SSI when they enrolled, and an equal share were receiving SSDI. Both figures are high compared to other states. In addition, the state suggested that individuals entering Freedom to Work from the 1619(b) category might be doing so in order to build up assets.

## MINNESOTA

**Overview.** Minnesota's Medicaid Buy-In program, Medical Assistance for Employed Persons with Disabilities (MA-EPD), was implemented in July 1999 under the authority of the Balanced Budget Act of 1997 and, in October 2000, was converted to the Ticket to Work and Work Incentives Improvement Act of 1999. Building on work they had done educating the disabled community about work incentives in the early 1990's, the Minnesota Consortium for Citizens with Disabilities provided the main impetus behind enactment of the MA-EPD program.

The program grew quickly, with approximately 5,000 enrollees within a year of the program's inception and 6,165 as of December 2004, making it one of the largest Buy-In programs. The rapid enrollment and growth of the program was a direct result of extensive outreach done by the disability community and advocacy groups. State officials also noted that the transfer of individuals from other Medicaid programs into the Buy-In was, and continues to be, an important factor fueling the program's rapid growth—at least 64 percent of new Buy-In participants in 2002 through 2004 were in Medicaid for at least one month during the year prior to enrollment. State officials also noted that enrollment grew early on because Medicaid served a large number of individuals in day training and habilitation facilities who subsequently transferred into MA-EPD.

Following its rapid growth initially, enrollment in Minnesota's Buy-In program actually decreased slightly in late 2001. This drop is most likely associated with changes to

Minnesota's Medicaid eligibility policy in July 2001, raising eligibility for regular Medicaid to 100 percent of the FPL (that is, the monthly threshold was raised from $612 to $716 for individuals) and eligibility for the medically needy program protected income level to 70 percent of the FPL (that is, to $501 from $482) (Jensen et al. 2002). The state raised the medically needy protected income level again in July 2002 to 75 percent of the FPL. These increases in the regular Medicaid thresholds allowed more people to qualify for regular Medicaid rather than the Buy-In, thus reducing the number of MA-EPD enrollees and stabilizing the level of program enrollment.

**Eligibility Criteria and Program Context.** MA-EPD extended Medicaid coverage to employed Minnesotans with disabilities age 16 through 64. Minnesota is unique in that its MA-EPD program has no upper limit for income eligibility and has an individual asset limit of $20,000, both of which are high relative to other Buy-In programs. Beginning July 2004, the first $65 of earned income is disregarded when determining eligibility for the program, which implies that a participant needs monthly earnings of greater than $65 to be eligible for the program.[7] In addition, Buy-In participants need to have Medicare and Social Security taxes withheld from wages or paid from self-employment earnings in order to provide proof of employment. Prior to July 2004, participants were exempt from this policy if their employer was not required to withhold these taxes.

Minnesota elected the Medicaid poverty level option for disabled individuals, providing these individuals with Medicaid eligibility if their monthly countable income is below the federal poverty line (that is, $776 in 2004). Both the medically needy protected income level in Minnesota ($582 in 2004, or 75 percent of the FPL) and state SSI benefit ($645 in 2004) are higher than in most other Buy-In states.

**Premium Structure.** All MA-EPD participants must pay a monthly premium that is based on a sliding fee scale with a minimum of $35.[8] There is no maximum income limit or maximum premium amount. Buy-In participants who have incomes at or above 300 percent of the FPL are charged 7.5 percent of their gross income. In addition, the state made two changes to its premium policies in November 2003: (1) participants who have unearned income pay an additional premium equal to 0.5 percent of their gross unearned income; and (2) the state ceased paying Medicare Part B premiums for MA-EPD enrollees with countable income above 200 percent of the FPL and now only these premiums for enrollees below this level.

**Other Policies.** Beginning in January 2004, MA-EPD participants may remain enrolled for up to four months without earnings if they become unable to work due to either medical reasons that are verified by a physician or an involuntary job loss. Prior to this change, the

[7]All Medicaid enrollees in Minnesota are subject to this disregard, which the state terms "Method B" budgeting. Prior to 2003, the state's Buy-In program was exempt from this policy.

[8]Prior to January 2004, only MA-EPD participants with incomes over 100 percent of the FPL paid a premium based on a sliding fee scale (that is, the minimum premium of $35 was not required).

program allowed participants to remain on the program if they were unemployed due to a verifiable medical condition.

## MISSOURI

**Overview.** Missouri established the Medical Assistance for Workers with Disabilities (MAWD) program under the authority of the Ticket Act in July 2002. Since implementation, enrollment has increased rapidly. At the end of 2004, the number of participants enrolled in MAWD (18,610) was more than double any other state program, despite the program being one of the more recent implementers (July 2002). The high enrollment may be driven partly by an influx of individuals from the state's spend-down program, as well as active outreach from the state's disability community. As part of an overall effort to constrain the rising cost of its Medicaid program, Missouri eliminated its Buy-In program as of August 28, 2005. State personnel noted that high enrollment in the Buy-In program (and thus its high cost), coupled with anecdotal evidence of large numbers of participants who were said to be engaged in minimal work efforts primarily to reduce their out-of-pocket expenditures, caused it to lose support among legislators.

**Eligibility Criteria and Program Context.** To be eligible for MAWD, a person with disabilities must have earnings from employment or self-employment and gross income less than 250 percent of FPL. The person also must have resources less than $1,000—the most restrictive assets test of any Buy-In program in the nation. The low resource requirement likely shrinks the pool of individuals who are eligible for the program.

Missouri is a 209(b) state, a designation that allows the state to use more restrictive eligibility criteria than are used by SSI. The 209(b) states do not have a medically needy pathway to Medicaid, per se, but they must offer a spend-down option for eligible individuals. Prior to October 2002, the state's Medicaid program paid all medical bills, including the spend-down amount, for persons with disabilities in the state's spend-down program. As of October 2002, the state stopped paying the spend-down amount, and this caused the out-of-pocket costs for individuals in the spend-down program to increase substantially. Consequently, many individuals in the Medicaid spend-down program moved to the Buy-In program because the Buy-In premium was often less burdensome than the spend-down amount.

Missouri does not use the SSI methodology to determine income eligibility for the Buy-In program; instead, the determination is based strictly on a gross income test. For some participants, especially those with low unearned income, this income counting methodology can be twice as restrictive as the SSI methodology (see Exhibit III.5 from Goodman and

Livermore 2004).[9] The state's relatively high 1619(b) income threshold was higher than the MAWD income threshold for an individual with no unearned income (Goodman and Livermore 2004), which should draw more people into the 1619(b) work incentive option rather than the Buy-In program.

**Premium Structure.** Participants with gross income less than 150 percent FPL pay no premium. The remaining participants fall into one of four premium categories ranging from four percent for the category with the lowest income level to seven percent for the highest income bracket. Sixteen percent of program participants enrolled for the entire fourth quarter of 2004 paid a premium, and the average monthly premium of those who were required to pay was $69.

**Other Policies.** The program offers no protection in the event of a job loss; unemployed individuals are disenrolled but may be moved to another Medicaid eligibility category. Missouri's MAWD program contains several income and asset exclusions for participants, including: (1) retirement accounts that are funded by earnings accrued while participating in MAWD; (2) medical expense accounts set up through the participant's employer; (3) family development accounts that have a religious or charitable community-based organization serving as the administrator; and (4) independent living development accounts that provide savings for several services (e.g., housing, personal assistance services). These exclusions are maintained until the participant reaches age 65 if the person is transferred to another Medicaid category.

**Program Experience.** Personnel in Missouri noted that the state's disability community is very well-informed which, in addition to the change in the spend down requirements, may have contributed to the program's rapid growth. Prior to implementation, the disability community heavily marketed the MAWD program. State officials noted that, when the spend-down rules changed, outreach by the disability community resulted in increased awareness of MAWD as an alternative to Medicaid eligibility and thus led many to transfer from the spend-down program to MAWD.

## NEBRASKA

**Overview.** Nebraska enacted its Medicaid Insurance for Workers with Disabilities program in July 1999 under the BBA 1997 legislation and had 67 enrollees as of end of 2004. Enrollment has been lower than expected, and this is likely due in large part to the program's eligibility criteria described below.

[9]The SSI methodology counts one-half of all earned income above $65, whereas Missouri is based on a strict gross income test. Therefore, the earnings limit for MAWD participants is significantly less than for participants in states that use the SSI counting methodology. For MAWD participants with low unearned income, this decrease in annual earnings potential is particularly striking and may be up to two times lower than other states.

**Eligibility Criteria and Program Context.** Eligibility for the Buy-In program in Nebraska involves passing a two-step income test:

- First, the sum of the spouse's earned income and the applicant's unearned income must be below the federal benefit rate (i.e., $564 in 2004). The applicant's unearned income is disregarded if (s)he is an SSDI beneficiary in a trial work period (TWP) as defined by Nebraska's Buy-In program.10 The TWP, as defined by Nebraska's Buy-In program, involved earning at least $579 per month (2004) in a given month.

- Once the first part of the income test has been passed, the applicant is eligible if countable family income, including unearned income, is below 250 percent of the FPL. Applicants can have up to $4,000 in assets ($6,000 for couples).

The disregard of all unearned income for SSDI recipients in a TWP has the effect of targeting individuals who are both on SSDI and participating in competitive employment. Given these requirements, it is not surprising that all first-time enrollees in Nebraska's Buy-In in 2004 were SSDI beneficiaries at enrollment. Being in a TWP as defined by Nebraska's Buy-In program, and thus having earnings above $579 (in 2004), greatly increases the likelihood of being eligible for the program, because all unearned income is disregarded.

An important component of the context of Nebraska's Buy-In program is the fact that the state has chosen to provide Medicaid coverage to disabled individuals with income below 100 percent of the FPL (i.e., $776 in 2004). Other important contextual factors in Nebraska include (1) a 1619(b) threshold of $2,321 per month; (2) a state supplement to the federal SSI benefit of $12 for a combined federal and state SSI benefit of $576 in 2004; and (3) a low medically needy income limit ($392 per month) relative to other Buy-In states with medically needy programs.

**Premium Structure.** Buy-In enrollees with countable family income between 200 and 250 percent of the FPL are required to pay a premium ranging from 2 percent of countable family income for enrollees from 200 and 209 percent of the FPL to 10 percent for enrollees from 240 to 249 percent of the FPL. The vast majority of Buy-In enrollees in Nebraska do not pay a premium—only two percent of participants enrolled for the entire fourth quarter of 2004 did so.

[10] For purposes of determining Buy-In eligibility, Nebraska considers the following as part of the trial work period (TWP): (1) the SSDI TWP (9 months); (2) the SSDI cessation month (month 10 following the beginning of the TWP); (3) the SSDI grace months (months 11 and 12 following the beginning of the TWP); and (4) the 36-month extended period of SSDI eligibility.

# NEW HAMPSHIRE

**Overview.** New Hampshire established the Medicaid for Employed Adults with Disabilities (MEAD) program on February 2002 under the authority of the Ticket Act. A total of 985 people enrolled in MEAD during its first year of operation, more than early estimates of 500 enrollees (Clark et al. 2003). MEAD participants also experienced substantially higher post-enrollment earnings, but did not significantly increase the costs to the state Medicaid program (Clark et al. 2003). Generous eligibility requirements and a major outreach effort are among the main factors that may contribute to growth of MEAD.

**Eligibility Criteria and Program Context.** New Hampshire is a 209(b) state and deviates from SSI methodology when determining Medicaid eligibility: an individual must have a medical impairment that has persisted or is expected to persist for a minimum of 48 months as opposed to a minimum of 12 months according to Social Security's definition of disability. New Hampshire's medically needy protected income level ($578) and combined federal and state SSI benefit ($591) are typical among all states with Buy-In programs. Its 1619(b) earnings threshold is third highest among the Buy-In programs in this report, which allows Medicaid recipients to earn more before losing coverage and suggests that the large number of individuals that are eligible for Medicaid under 1619(b) could limit the eligible population for the Buy-In program.

New Hampshire has particularly generous Buy-In eligibility criteria. The MEAD program allows participants to have net family income up to 450 percent of the FPL and assets below $21,370. The lenient income and asset test should attract many disabled workers to enroll in the Buy-In program. However, the state made the following changes in May 2005 that tighten eligibility requirements: (1) Buy-In participants must earn at least the federal minimum wage; (2) applicants must continue working while eligibility is being determined; and (3) assets that Buy-In participants acquire while on the program are no longer disregarded whey they transfer to regular Medicaid.

**Premium Structure.** MEAD charges no monthly premium if an enrollee's countable income is below 150 percent of the FPL. There are six premium categories for enrollees with countable income between 150 percent and 450 percent of the FPL, ranging from $80 to $220 per month. Employer-sponsored insurance premiums and Medicare premiums both are deducted from the Buy-In premiums. Thirty two percent of participants paid a premium in 2004, and the average monthly premium was $37. The state instituted a plan in February 2005 allowing individuals unable to afford the premium to pay it over a three-month period.

**Other Policies.** Like many other states, MEAD requires proof of employment at enrollment. Prior to May 2005, a program participant who lost a job but intended to return to work was able to remain on the program for up to one year. Beginning in May 2005, this grace period was shortened to six months, with a six-month extension when the participant provides documentation on his or her medical condition or employment search.

**Program Experience.** New Hampshire has made a major effort not only to promote the MEAD program, but also to help the state's disabled population seek and maintain employment. For example, grants were given to independent living centers to provide outreach for MEAD; MEAD benefits specialists, located at One-Stop centers, were mobilized to provide benefits evaluation and education; and the state helped to sponsor an annual conference focusing on disabilities, diversity, and employment, including a job fair in conjunction with an exhibition on assistive technology for people with disabilities.

## NEW JERSEY

**Overview.** New Jersey's Buy-In program, NJ Workability, was implemented in February 2000 under the authority of the Ticket Act of 1999. Enrollment in the program reached 951 by the end of 2003.

**Eligibility Criteria and Program Context.** New Jersey provides categorical Medicaid eligibility for persons with disabilities whose incomes are less than 100 percent of the FPL ($776 per month in 2004). Hence, although the medically needy protected income threshold is relatively low in New Jersey ($367 per month), many disabled persons with higher incomes still can qualify for Medicaid eligibility. First-time enrollees in NJ Workability were less likely than enrollees in other Buy-In programs to have been in Medicaid during the year prior to Buy-In enrollment—55 percent of first-time enrollees in 2004 had been, compared to 65 percent across the 28 Buy-In programs analyzed in this report.

NJ Workability's average income eligibility limit (250 percent of the FPL) and relatively high asset limit ($20,000 for individual) may promote enrollment. However, the program also has a separate unearned income limit. As a result, persons with disabilities who have unearned income (for example, pensions, interest, private disability or retirement benefits) above 100 percent of the FPL after disregarding SSDI benefits would not be eligible to enroll in the program, which may restrict Buy-In enrollment. Therefore, the net effect of these policies on the enrollment level is unclear.

**Premium Structure and Other Policies.** New Jersey has a flat-rate premium requirement ($25 per month for an individual and $50 for couples) for participants with incomes greater than 150 percent of FPL. However, the state does not collect premiums because the revenue from doing so would not offset the administrative cost. In the event of a temporary job loss, a person with disabilities may stay on NJ Workability if he or she has worker's compensation or Temporary Disability Insurance (TDI) and is still employable (that is, the worker intends to return to work). The protection period can be as long as 26 weeks for people with TDI.

**Program Experience.** New Jersey continued its extensive outreach activities in 2004 by conducting, for example, presentations about the program and distributing informational materials. In 2003, according to program staff, over 300 training sessions were given to non-

profit organizations, front-line caseworkers, and other state agencies, such as the Social Security office, Vocational Rehabilitation services, etc.

## NEW MEXICO

**Overview.** The Working Disabled Individuals (WDI) program, New Mexico's Buy-In program, was launched on January 2001 under the authority of the Balanced Budget Act (BBA) of 1997. Enrollment in WDI was 1,181 as of December 2004. The program offers health coverage for many non-working individuals in the 24-month waiting period for Medicare in addition to working people with disabilities.

**Eligibility Criteria and Program Context.** Eligibility for the WDI program requires that persons with disabilities be age 18 and over and pass both an earned and an unearned income test. First, applicants must have countable income at or below 250 percent of the FPL, and have resources of at most $10,000 ($15,000 for couples). Second, WDI requires that participants have less than $1,148 per month (in 2004) of unearned income.

Qualifying for WDI also requires that a person with disabilities have a recent attachment to the workforce, defined as having gross earnings in a quarter sufficient to meet SSA's definition of a "qualifying quarter" (that is, $900 in 2004).[11] SSDI recipients who are in the two-year waiting period for Medicare are not required to work in order to maintain eligibility until the waiting period ends.

Health coverage options for persons with disabilities in New Mexico, other than WDI, are limited. New Mexico does not have a medically needy program or provide categorical Medicaid eligibility to persons who have a low income. In addition, the state does not provide a state supplement to the federal SSI benefit, and its 1619(b) income threshold ($2,119 per month) is lower than many Buy-In states.

**Premium Structure.** Instead of collecting monthly premiums, WDI requires participants at all income levels (except for Native Americans) to pay copayments for certain services and items at the time of service. Beginning January 2004, the co-payments increased from a range of $2 to $25 to a range of $5 to $30. One state official anticipates that, beginning in Fall 2005, a premium and enrollment fee may also be required of Buy-In participants.

**Other Policies.** Although New Mexico does not directly provide protections for temporary loss of employment, participants can still maintain their eligibility for the whole quarter, as long as they show proof of employment at the beginning of the quarter. Therefore, the WDI program, in effect, has a grace period of up to three months during

[11] This state-imposed requirement is contrary to the BBA and Ticket statutes and CMS regulations.

which participants could remain enrolled after having lost their job. However, if a client does not report a change in income, then he or she could potentially remain on the program until the next recertification.

## NEW YORK

**Overview.** New York implemented its Medicaid Buy-In for Working People with Disabilities (MBI-WPD) program in July 2003 under the authority of the Ticket Act of 1999. New York is one of the few states that chose to have a Medical Improvement Group, which allows a disabled individual to remain enrolled in MBI-WPD after their disability improves if they continue to retain a severe medical impairment, work at least 40 hours per month and earn at least the federal minimum wage. No one has yet enrolled under the Medical Improvement Group. Enrollment in the MBI-WPD program more than tripled in 2004, the program's second year in existence, growing from 702 in December 2003 to 2,480 one year later.

**Eligibility Criteria and Program Context.** The MBI-WPD program provides Medicaid coverage for disabled individuals age 16 to 64 with countable income at or below 250 percent of the FPL and assets at or below $10,000. The combined federal SSI benefit and state supplement in New York for 2003 ($651) is higher than most other Buy-In states, as are the income thresholds for 1619(b) ($2,879) and its Medically Needy program ($659).

**Premium Structure.** MBI-WPD policy requires enrollees with countable income that is at or above 150 percent of the FPL to pay a premium equal to the sum of 3 percent of net earned income and 7.5 percent of net unearned income. However, the state currently is not collecting premiums while it implements an automated premium payment collection and tracking system, which is expected to be functioning in 2006.

**Other Policies.** MBI-WPD participants can maintain their enrollment for up to 6 months in a 12-month period if they are unable to work due to (1) health reasons; or (2) involuntary loss of employment, assuming they intend to return to work.

**Program Experience.** State personnel anticipate continued enrollment growth, potentially reaching as many as 20,000 enrollees within five years of the program's implementation, as outreach activities and awareness of the program continue. Outreach activities for MBI-WPD have thus far involved using the Medicaid Infrastructure Grant to fund outreach and education contractors that are providing information and education to specific target populations. In addition, state personnel have put together printed materials to disseminate program-related information—for example, they have produced a color brochure and a "toolkit" to help community advocates effectively spread the word about the program.

# NORTH DAKOTA

**Overview.** North Dakota's Workers with Disabilities Coverage program was passed on May 3, 2004, under the Ticket Act of 1999 and went into effect on June 1, 2004. The disability advocacy community was actively involved in creating the program, as was the state Medicaid director. Two committees took the lead in shaping and implementing the legislation: the implementation committee, consisting mostly of consumers, providers and advocates; and the steering committee, which was made up of legislators, the state Medicaid director, and several other heads of state agencies. The eligibility criteria were selected on the basis of what the steering committee thought the legislature would approve. The program was designed to target the SSDI population, those in the Medically Needy program, and other working people with disabilities. By the end of 2004, 258 people had enrolled in the program, roughly 10 percent more than the 225 initially projected. Since the initial growth spurt, enrollment has leveled off, although the state expects more growth in 2005.

**Eligibility Criteria and Program Context.** North Dakota's low countable net income threshold (225 percent FPL) is among the most restrictive relative to other states. However, the absence of an unearned income limit and a moderately generous asset limit ($13,000 plus burial accounts) make the overall criteria less restrictive than many other programs. Although North Dakota does not have a poverty level Medicaid option, there is a Medically Needy program with an income threshold of $500 per month.

**Premium Structure.** All enrollees must pay a premium equal to five percent of his or her income. The average premium paid in 2004 was $58. In addition, each person must pay a one-time enrollment fee of $100. If premiums remain outstanding for three months, individuals are terminated from the program.

**Other Policies.** Because North Dakota does not have a grace period, job loss will result in disenrollment from the program. However, the state allows an individual to quit one job and take another even if the new position does not begin during the next full calendar month. In addition, if an individual falls ill for an extended period and is planning and able to return to work, he or she will not lose benefits.

**Program Experience.** The original legislation had a sunset review clause that required the program to be reauthorized by June 30, 2005. As a result of that review, several program features were changed, including the age range (expanded from 18-65 to 16-65) and the asset limit (an additional $10,000 to be dedicated to an individual's Plan for Achieving Self-Support was combined with the Medicaid asset limit of $3000 for a total of $13,000 in allowable resources).

North Dakota has done a significant amount of outreach, including a campaign that involved a 30-second television spot that aired for five months as well as an international award-winning promotional video. Information packets were also sent to county Social Security offices, disability advocates, and individuals on the implementation committee. In

total, North Dakota estimates that it has distributed 700 to 800 packets. Formal outreach, as well as word of mouth, has informed North Dakotans about the Workers with Disabilities Coverage program.

## OREGON

**Overview.** Oregon was the first state in the country to implement a Medicaid Buy-In program under the authority of the BBA (February 1999). As part of a comprehensive work incentives initiative, Oregon's Employed Persons with Disabilities (EPD) program targeted those who are most ready to work but might not due to a fear of losing health care coverage. Some observers have argued that it is the truest example of a work incentives program because of the program's cost-sharing structure and work requirement.

**Eligibility Criteria and Program Context.** To be eligible for the EPD program, a person with disabilities must have taxable income, earnings less than 250 percent of the FPL (unearned income is disregarded), and assets less than $5,000. Oregon's relatively low income eligibility threshold 1619(b) and for its SSI state supplement in addition to the absence of a Medically Needy program (it was eliminated in February 2003) should contribute to a large pool of disabled individuals compared to other states who may be eligible for EPD.

Oregon implemented three major changes to its Medicaid program in 2003 that may have affected Buy-In enrollment. First, Oregon's Department of Human Services eliminated its medically needy program on February 1, 2003 as part of a statewide deficit-reduction plan. Many individuals previously enrolled in the medically needy program transitioned to the EPD program. This shift increased the percentage of new EPD participants who were in Medicaid prior to enrolling in EPD (from 77 percent in 2002 to 88 percent in 2003), and especially increased the percentage of these individuals who were previously enrolled in Medicaid through the medically needy program (from 27 percent in 2002 to 42 percent in 2003).

Second, the state instituted an "Attachment to the Workforce" policy in May 2003, which requires that participants earn at least $900 per quarter to enter or remain in the program.[12] Low-income EPD participants would have been deemed ineligible for the program and thus program enrollment could have dampened as a result of this policy.

Third, the asset limit for an individual was lowered from $12,000 to $5,000 as of July 1, 2003.[13] Participants were given a one-year grace period and were permitted to move assets

[12] This state-imposed requirement is contrary to the BBA and Ticket statutes and CMS regulations.

[13] In Oregon, retirement accounts, medical savings accounts, and approved accounts for employment or independence are all excluded from countable assets.

into an approved account (if eligible). EPD staff have closely monitored the effects of the asset limit reduction and have not seen any direct evidence that this policy has caused enrollment to decline. Furthermore, a consumer focus group conducted by the Oregon Health Policy Institute did not identify any client concerns with this policy change.

Overall, EPD enrollment dropped from 739 in March 2003 to 585 the following December, which may have been in response to the new earnings requirement, the drop in the asset limit, or both of these policies. EPD enrollment has since remained steady and was at 583 in December 2004.

**Premium Structure.** One deterrent to enrollment in EPD may be its cost-sharing structure (Fishman and Cooper 2002, Hanes et al. 2002, Hanes and Folkman 2003). Participants in EPD pay a monthly premium on earned income and a "cost share" based on unearned income.[14] The "cost-share" is equal to all unearned income above the SSI monthly benefit standard ($564 per month in 2004). The premium on earned income is equal to gross income plus any unearned income remaining after the cost share is paid minus (1) mandatory taxes; (2) approved employment and independence expenses; and (3) 200 percent of the federal poverty level, and multiplying the remainder by 2 to 10 percent. The cost share likely serves as a deterrent to enrollment for individuals with high unearned income, particularly those with large SSDI benefits. Only individuals most confident in their ability to maintain overall income given the premium requirements would likely enroll in EPD. The premium and cost share requirements, together with a strict employment requirement at enrollment, reflect EPD's original intent as a work incentive initiative and may contribute to both the steady enrollment and higher levels of post-enrollment employment and earnings in Oregon (Hanes and Folkman 2003).

## PENNSYLVANIA

**Overview.** The Medical Assistance for Workers with Disabilities (MAWD) program began in January 2002 under the authority of the Ticket Act. Pennsylvania is one of the few states that included both the basic and medically improved group.[15] Enrollment has grown consistently since program implementation and reached 4,865 enrollees as of December 2004.

[14]The "cost share" is essentially a premium on unearned income.

[15]To be eligible for the Basic Insurance Group, one must be certified as disabled based on the SSI/SSDI criteria (with the exception of the requirement that (s)he be unable to work) and be employed and receiving compensation. Eligibility for the medically improved group involves (1) having a medically improved disability; (2) having previously been a worker with a disability who participated in medical assistance; and (3) employed at least 40 hours per month for at least minimum wage. State officials noted that no one has yet enrolled under the medically improved group.

**Eligibility Criteria and Program Context.** Persons with disabilities age 16 up to 65 are eligible for MAWD in Pennsylvania if they are employed and receive compensation, have countable income below 250 percent of the FPL, and have countable resources at or below $10,000. The state has a 1619(b) income threshold of $1,871 per month and has a combined federal and state SSI benefit of $591.40.

Pennsylvania has elected the poverty-level option for its Medicaid program; persons with disabilities who have incomes below 100% of the FPL are eligible. Pennsylvania also has a medically needy program with an income threshold of $425 per month, but state officials noted that some individuals may choose not to apply, because the program does not cover prescription drugs. Therefore, medical assistance provided through Medicaid's poverty-level option or MAWD, both of which cover prescription drugs, may often be preferable for persons with disabilities who have these options. Prescription drug coverage is a particularly salient issue for MAWD enrollees, because about 50 percent of program participants have mental health problems, for which the need for prescription drug coverage is often more acute than many other disabling conditions.

**Premium Structure.** MAWD participants are required to pay a premium equal to 5 percent of their countable income. County workers have been given an increasing amount of flexibility to keep participants in the program if they are unable to pay their premium; early on, many of these participants would have disenrolled. Data from 2004 indicate that approximately 94 percent of MAWD enrollees paid a premium that averaged $46 per month.

**Other Policies.** Pennsylvania's MAWD program has a number of other policies that are worthy of note:

- If an enrollee is unable to work due to health problems or job loss (referred to as "good cause"), they can remain on the program with their premium waived for up to two months. In an effort to minimize churning, the state has broadened the definition of "good cause."

- Pennsylvania has a number of Medicaid waivers designed to assist individuals with disabilities and the elderly by providing services designed to promote independence and prevent institutionalization. Program staff noted that they have worked to inform persons with disabilities that they should apply for both MAWD and waiver services.

- To prevent a potential enrollee from going without health coverage during the disability determination process, the state began providing coverage under MAWD while this process is underway as of October 2004.

- Because verification requirements were not consistent across state agencies, the state developed a self-employment verification form.

**Program Experience.** State officials noted that MAWD has caused a fundamental shift in the approach among some staff in County Assistance Offices (CAO) to the eligibility

determination process. Now, rather than go strictly "by the book" when conducting an eligibility determination, intake workers make an extra effort to get their clients into the appropriate program.

## SOUTH CAROLINA

The Medicaid for the Working Disabled program was implemented under the Balanced Budget Act of 1997 (BBA) on October 1, 1998. Federal legislation shaped the program, adhering strictly to the BBA regulations, but the state's fiscal situation has lead to limited expansion of eligibility requirements. South Carolina has made only one change to its Buy-In program since it was launched in 1998: 401(k) accounts have been excluded from countable assets. According to state personnel, the Buy-In program was designed more to expand health insurance coverage and less to create a work incentive for people with disabilities. Compared to other states, South Carolina has the lowest enrollment per 100,000 residents. Enrollment has also fluctuated since the program's inception in 1998. In the first quarter of that year, there were 8 enrollees by September 2001, the number rose to 88, only to fall and slowly decline to 46 by June 2003. Enrollment has since rebounded slightly, reportedly rising to 52 in December 2004.

**Eligibility Criteria and Program Context.** South Carolina offers a categorical Medicaid option for people with disabilities who earn less than 100 percent FPL and have less than $4000 in assets. (For a couple, the limits are higher: $1041/month income and $6000 in assets.) Interestingly enough, the option allows enrollees to have more assets than are allowed in the Buy-In program. This is unusual given that the latter is often used to allow people with disabilities to have higher earned income and resources. However, the $2,000 asset limit in the state's Buy-In program is mandatory under the BBA. There is no Medically Needy category in South Carolina. For Buy-In enrollees, the eligibility requirements are more stringent than in most states. Countable income is limited to 250 percent FPL and includes income from both the individual and his or her spouse. In addition, the monthly unearned income limit was $564 as of 2004. The $2000 individual asset limit excludes spousal resources and 401(k) accounts. While South Carolina did not explicitly define "work" in the program, the state is unique in its earnings minimum of $810 per month (as of 2004).[16] To that end, South Carolina requires enrollees to verify income during the annual re-certification in the form of a pay stub or employer letter. However, documentation for the payment of income and FICA taxes is not required. According to the state, vocational rehabilitation and benefits counselors often cite the unearned income limit and the earnings minimum as the greatest barriers to program enrollment.

**Premium Structure**. Although the standard Medicaid co-payments are required of Buy-In enrollees, there is neither a premium nor a co-payment specific to the program. The

[16] This state-imposed requirement is contrary to the BBA and Ticket statutes and CMS regulations.

state's rationale for excluding a premium is that the administrative costs associated with collecting and otherwise managing it would outweigh what the state would collect in total premiums.

**Program Experience**. According to state personnel, there is a general lack of knowledge about the program among potentially eligible individuals. As a result, South Carolina planned to step up its outreach efforts in 2005 by, for example, working with 18 disability organizations to disseminate information about the Medicaid for Disabled Workers program. The state has also targeted about 300 consumers with disabilities for intensive training that would expand their knowledge of the program and other work incentives.

## UTAH

**Overview.** The Medicaid Work Incentive Program (MWI), Utah's Buy-In program, was enacted on July 1, 2001 under the authority of the Balanced Budget Act of 1997. It was implemented as part of the Utah Work Incentive Initiative (UWIN), a broader initiative coordinated across several state agencies to better inform and support people with disabilities in their employment. In addition to the Medicaid Buy-In program, UWIN includes resources such as: the Utah Benefits Planning Assistance and Outreach (UBPAO) to educate SSDI beneficiaries on the effect of employment on benefits eligibility; personal assistance services available under the Medicaid state plan, available Ticket to Work supports; and information resources available for employers seeking to hire qualified individuals with disabilities. Utah had 260 enrollees as of December 2004. Enrollment dipped sharply from 230 in June 2002 to 170 the following September due to a large premium increase that occurred in July 2002.

**Eligibility Criteria and Program Context.** A Utah resident with disabilities is eligible to enroll in the MWI program if (1) the individual is working; (2) family income is at or below 250 percent of the FPL and (3) family resources less than $15,000.[17] Perhaps most notable about the context in which the MWI program operates is that beginning in July 2003, the medically needy protected income level increased from $386 to 100 percent of the FPL (that is, $776 in 2004), making it higher than any other state with a Buy-In program. In addition, Utah has elected to have a poverty level option for its Medicaid program, thus establishing the income threshold for Medicaid eligibility at 100 percent of the FPL. Utah does not provide a supplement to the federal SSI benefit, and Utah's 1619(b) threshold of $1,634 per month is low relative to other Buy-In states.

**Premium Structure.** Buy-in participants with income levels of at least 100 percent of the FPL are required to pay premiums equal to 15 percent of a participant's countable income. The vast majority of participants enrolled in the fourth quarter of 2004 (88 percent)

[17]Both the income eligibility threshold and the resource limit include spousal income/resources.

paid premiums averaging $162 per month, which is high compared to other Buy-In states. As noted above, Utah increased its MWI premium in July 2002 from 20 percent of countable income to a range from 30 to 55 percent of countable income. In some cases, this change "caused premiums to quadruple," and this was followed by sharp decrease in enrollment as noted above (Julnes et al. 2003). In July 2003, however, the premium structure was revised a second time and remains 15 percent of countable income. This change caused the average premium among premium payers to decrease from $321 in 2002 to $145 in 2003.

**Other Policies.** Utah initially had a policy whereby MWI enrollees who lost their job involuntarily could remain in the program for up to 12 months, but this policy was eliminated as of July 2002.

**Program Experience.** Focus group results presented in Julnes et al. (2003) suggest that the MWI program has received positive reviews from participants. In addition, data from a telephone survey illustrate how the MWI program has helped enrollees. Nearly half (46 percent) of MWI participants who had been continuously enrolled in the program from its inception through August 2002 noted that the program had helped them "go to work," and 12 percent noted that enrollment allowed them to "take on more responsibilities" (Julnes et al. 2003). However, this study found that the premium increase that occurred in July 2002 had a substantial impact on program participants. Thirteen of the sixteen MWI participants interviewed who had disenrolled and returned to the program at least twice noted that they cycled on and off of the program because the premium was unaffordable (Julnes et al. 2003).

## VERMONT

**Overview.** Medicaid for Working People with Disabilities (WPWD), Vermont's Medicaid Buy-In program, was implemented in January 1, 2000 under the authority of the Balanced Budget Act (BBA) of 1997. WPWD was implemented as part of the Vermont Work Incentives Initiative (VWII), a broader initiative seeking to implement and advocate system-wide reforms to support people with disabilities in employment. The VWII, in addition to implementing a Medicaid Buy-In program, provides benefit counseling for individuals with disabilities.

As of December 2004, Vermont had 520 enrollees in the WPWD program. This enrollment may be limited by a number of factors (described below), including the separate unearned income limit, the lack of work stoppage protection, and the availability of an array of other public options for health care coverage.

**Eligibility Criteria and Program Context.** WPWD has a two-step income test: 1) employed persons with disabilities must have a family net income less than 250 percent of

FPL, and 2) income does not exceed either the Medicaid protected income level or the SSI payment level, whichever is higher, after disregarding the earnings and up to $500 of SSDI benefits of the individual.[18] The program's resource limit is set at $2,000 per individual and $3,000 per couple at enrollment.[19] After enrollment, there is no limit on the amount of assets that may be accumulated from the earnings of the person with disabilities, provided liquid assets from such earnings are kept in a separate bank account.[20] The separate unearned income eligibility may prevent many SSDI beneficiaries from meeting income eligibility criteria.[21] This, combined with the low asset limit of $2,000 at enrollment, may contribute to the program's low enrollment. In addition, the WPWD program may be intended to fill a narrow eligibility gap, as Vermont residents with low incomes already have access to a wide array of health care coverage options, most notably the Vermont Health Access Plan (VHAP), a Section 1115 waiver.

Vermont has a high medically needy protected income level of $800 per month compared to other states, which makes it easier for eligible persons to meet the spend-down amount and lessens the relative advantage of enrolling in the Buy-In to avoid a large spend-down.

**Premium Structure**. Buy-In participants with income levels below 185% of the FPL are not required to pay premiums. The WPWD program has two income brackets that require a premium: before July 2003, those earning between 185-225 percent of FPL paid $20, and those earning between 225-250 percent of FPL paid $24 per month. Starting in July 2003, the monthly premium rose to $50 and $60, respectively. Only 8 percent of Buy-In participants paid a premium in the fourth quarter of 2003, and the average monthly premium for these participants for that quarter was $27. The state eliminated the premium requirement in June 2004 to reduce its administrative burden. However, WPWD participants continue to be required to pay nominal cost sharing in the form of copayments and coinsurance that is required of all Medicaid beneficiaries.

**Program Experience.** Vermont eligibility staff and benefit counselors are trained specifically on the WPWD program. The state also has disseminated pamphlets and other educational materials about the program. While the state covers personal assistance services (PAS), only a small handful of program participants receive these services, possibly because the approval process is extensive and lengthy, and possibly because the majority of consumers who would meet the activities-of-daily-living or institutional-level-of-care

[18] Beginning September 15, 2005, the state will disregard all unearned income from SSDI and veteran's benefits.

[19] The asset limit at enrollment was increased as of September 15, 2005 to $5,000 per individual and $6,000 per couple.

[20] This provision was eliminated as of September 15, 2005.

[21]The average SSDI benefit nationally was $862 in December 2003 (Social Security Administration 2004). Thus, it is likely that many SSDI beneficiaries would not be eligible for the Buy-In program.

eligibility criteria for PAS have already acquired health coverage under an alternative program and are not currently seeking the earnings protection of the Buy-In.

In an effort to more clearly define the types of income that considered valid for eligibility determination purposes, the state, beginning September 15, 2005, began requiring that participants demonstrate that their earnings were subject to Federal Insurance Contributions Act (FICA) taxes. Self-employed individuals will be required to show evidence of Self-employment Contributions Act (SECA) taxes or a business plan supported by a third-party investor or funding source.

## WASHINGTON

**Overview.** Washington adopted its Buy-In program, Healthcare for Workers with Disabilities (HWD), in January 2002 under the authority of the Ticket Act. It is one of a few states that elected to cover both the Basic Coverage Group and the Medical Improvement Group. No one has enrolled in the Medical Improvement Group as of yet because this group has not been defined at the federal level. As of December 2004, enrollment in the program had reached 448. Although this number almost doubled that of the previous year, enrollment remained relatively low compared to most other Buy-In programs. An economic downturn, the short program history, and some program features (highlighted below) may have contributed to the slow growth of HWD.

**Program Context and Eligibility Criteria.** Washington's general Medicaid eligibility is typical among states with a Buy-In program – its combined federal and state SSI benefit ($570.90) and medically needy protected income level ($571) are relatively generous compared to many other states with Buy-In programs. However, Washington has not chosen to provide categorical Medicaid eligibility for persons with disabilities, and the state's low 1619(b) earning threshold ($1,762 in 2004) relative to other Buy-In states suggests that a large number of people may be eligible for HWD.

HWD has at least one distinctive eligibility criterion that may facilitate enrollment. Individuals do not have to meet any asset test to be eligible for HWD, in addition to having net income less than 220 percent of the FPL. The absence of an asset test enlarges the pool of potential Buy-In participants and encourages existing enrollees to accumulate assets.

**Premium Structure**. All HWD participants enrolled during the entire fourth quarter of 2004 paid a premium based on both unearned and earned income. The premium level is the lesser of 7.5 percent of total income or the sum of the following: 50 percent unearned income above the Medically Needy Income Level (MNIL) ($571 in 2004), plus 5 percent of total unearned income, plus 2.5 percent earned income after a $65 deduction. Premiums among Buy-In participants averaged $86 per month in 2004. This amount is higher than most states with Buy-In programs, and may act as a disincentive for some eligible individuals to enroll in the Buy-In program.

**Other Policies**. Participants in the Basic Coverage Group must have earnings subject to federal income taxes, and self-employed participants must provide tax forms or business license/records. Participants in the Medical Improvement Group must work at least 40 hours per month and earn at least minimum wage. If HWD participants lose their job, they can choose to continue enrollment through the end of their current 12-month certification period, as long as (1) the job loss is due to a health crisis or involuntary dismissal; (2) they intend to return to work; and (3) they continue to pay monthly premiums based on their remaining income.

**Program Experience.** Because of state budgetary pressures, rescinding the HWD program was proposed in 2003. The program survived, partly due to strong support for it among the disability community. Outreach activities in 2003 were temporarily scaled down but became more intensive in 2004.

## WEST VIRGINIA

In April 2003, West Virginia established the Medicaid Work Incentive (M-WIN) under the Ticket Act of 1999, covering both the basic and the medically improved groups. Enrollment in this very politically popular program began on May 1, 2004. The intent of the program was to both create a work incentive for people with disabilities and expand heath insurance coverage. Currently, the only entrance into the program is through enrollment in the basic coverage group. The medically improved coverage group acts as an ancillary route to benefits for those who, through the social security redetermination process, may no longer be considered disabled according to the Social Security Administration's definition. Thus far, only one individual has moved from the basic to the medically improved group.

**Eligibility Criteria and Program Context.** Seven months after M-WIN was implemented, enrollment stood at 84 individuals. This figure is in line with the state's initial estimates of 180 enrollees after 18 months. The low level of enrollment relative to other states is likely due to West Virginia's eligibility requirements, which are intentionally restrictive given that the state has the highest disability rate in the nation, with 7.4 percent of its working population, or approximately 84,000 workers, receiving SSDI benefits (SSA 2004). About 26 percent of these individuals receive payments of $600 per month or less (SSA 2004), and the state could not afford to cover all of them if they decided to enroll in the Buy-In program. The countable income limit, based on individual earnings, is 250 percent FPL, and the unearned income limit was $584 in 2004. An individual may have $5,000 in liquid asset exclusions, in addition to the $2,000 asset limit, and a couple may have $10,000 in liquid asset exclusions, with a $3,000 asset limit. Retirement accounts are excluded from countable assets, as are independence accounts. Basic group enrollees must be engaged in competitive work in an integrated setting earning at least minimum wage. Those who move into the medically improved group are subject to the same eligibility criteria as the basic group except that they must earn a monthly wage equivalent to working

40 hours per month at minimum wage. All enrollees are required to verify income through, for instance, a pay stub, self-employment records, or an employer letter, but they do not have to document payment of FICA or income taxes.

The unearned income limit of $584 is likely to have been responsible for the fact that only 9 percent of the current Buy-In enrollees were receiving SSDI when they enrolled, which is much lower than the average of 65 percent across all 28 states covered in this report. When the program was being designed, West Virginia was trying to target individuals not eligible for SSI because they were over the asset limit as a result of the preponderance of generational farm ownership. The state seems to have reached this goal, as over 70 percent of enrollees were not receiving Medicaid when they enrolled in the Buy-In program. Of the roughly 28 percent who did come from Medicaid, 83 percent were enrolled in the Medically Needy group, the spend down of which is $200.

**Premium Structure.** The M-WIN premium is based on a sliding scale according to the average monthly gross income, established every 6 months. The premium amount ranges from a minimum of $15 to no more than 3.5 percent of an individual's gross annual income. Each individual must also pay a $50 enrollment fee, which includes the first month's premium. Medicaid coverage begins on the first day of the month following payment of the enrollment fee.

**Other Policies.** M-WIN has a grace period under which enrollees who have lost their jobs will not lose their Medicaid benefits for six months as long as they submit a written request to continue their coverage within 30 days of job termination. In addition, they must continue to pay monthly premiums and maintain a connection to the workforce by enrolling in a vocational rehabilitation program, registering with the Office of Work Force Development, participating in a transitional school-to-work program, or providing documentation from their employer stating that they are on temporary involuntary leave.

**Program Experience.** Although the state has done quite a bit of outreach, it has not organized a media-based public awareness campaign. Department of Health and Human Resources offices as well as consumer and advocacy groups have been educated about the program, and the state plans to conduct more outreach in 2005.

## WISCONSIN

**Overview.** Wisconsin established its Medicaid Purchase Plan (MAPP) in March 2000 under the authority of the Balanced Budget Act as a program designed to increase work incentives for persons with disabilities. Enrollment was "modest" during the program's first year of implementation (Innovative Resource Group 2002). Since then, however, enrollment has grown more quickly, and the MAPP has become the second largest Buy-In program in the nation with 7,713 participants as of December 2004.

**Eligibility Criteria and Program Context.** Wisconsin's MAPP program is available to persons with disabilities age 18 and over with net countable income up to 250 percent of the FPL and resources up to $15,000. In addition, MAPP participants are allowed, once enrolled, to accumulate assets above the resource limit (APS Healthcare 2003).[22] Compared to other states with Buy-In programs, MAPP has an above-average combined federal and state SSI supplement ($683) and protected income level for its medically needy program ($592). These factors, in conjunction with a relatively high monthly 1619(b) threshold of $2,304, suggest that a large proportion of individuals with disabilities in Wisconsin may already be eligible for Medicaid through other pathways.

**Premium Structure.** MAPP participants with countable income from 150 to 250 percent of the FPL pay a premium equal to the sum of (1) 3 percent of an individual's earned income, and (2) 100 percent of unearned income less the standard living allowance and exclusions. The vast majority of MAPP participants (90 percent) enrolled in the fourth quarter of 2004 did not pay a premium, suggesting that the countable income among these individuals was below 150 percent of the FPL. Premiums among the 10 percent of participants who paid a premium averaged $143.

**Other Policies.** If MAPP participants do not have earnings from work, they may participate in health and employment counseling (HEC) for up to a year, after which earnings from employment are required. Based on the most recent evaluation report, few MAPP participants take advantage of the option to participate in HEC—68 individuals were actively doing so in July 2002 (APS Healthcare 2003). For MAPP participants with health problems that prevent them from working, Wisconsin waives the work requirement for up to 6 months. However, information from a focus group suggests that this work protection feature may be less attractive in practice than initially expected because (1) it requires participants to have been enrolled in the Buy-In program for at least six months, and (2) it only can be used twice every three years (Innovative Resource Group 2001).

**Program Experience.** The slower than expected enrollment growth early in the program may have been due in part to the following factors:

- Enrollment was initially cumbersome because MAPP county workers conducted the eligibility determination process manually until fall 2001, when this process was automated (APS Healthcare 2003)

- Training of county economic support (ES) workers did not begin until after MAPP was implemented, and a survey of ES workers found that only one in four workers felt that their MAPP training was sufficient (Innovative Resource Group 2002).

- Comments from program participants suggest that information about the program could be disseminated more effectively (APS Healthcare 2003).

[22]Only one percent of MAPP participants in June 2003 had pursued this option.

One outreach activity in the early stages of implementation is called Local Collaborations. Local Collaborations is designed to inform MAPP participants about available work incentives by convening groups of MAPP participants and area employment professionals to discuss employment and benefit concerns on an ongoing basis.

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# APPENDIX B

# INSTRUCTION GUIDE FOR COMPLETING THE ANNUAL BUY-IN REPORT ON PROGRAM PARTICIPATION

# The Medicaid Buy-In Program:

## Completing the Annual State Report on Program Participation in Calendar Year 2004

## Instruction Guide

Prepared by Mathematica Policy Research, Inc.
for the Centers for Medicare & Medicaid Services

# Data Element 1: Enrollment Totals

## A. Wording

1(a) How many individuals enrolled for the first time in the Medicaid Buy-In program during calendar year 2004? (The "first-time" group)

1(b) How many individuals re-enrolled in the Buy-In program during calendar year 2004? (The "re-enrolled" group)

1(c) How many individuals were enrolled in the Buy-In program for the entire 12 months of 2004? (The "continuously enrolled" group)

1(d) How many individuals were enrolled in the Buy-In program for the entire fourth quarter of 2004? (The "fourth-quarter" group)

1(e) How many individuals were enrolled in the Buy-In for the entire fourth quarter of 2003 ***and*** for the entire fourth quarter in 2004? (The "longitudinal" group)

1(f) How many individuals have been enrolled in the Buy-In program since its inception? (The "cumulatively enrolled" group)

Recommended data source for Element 1: MMIS eligibility file

## B. Instructions

A person is considered "enrolled" if that person is included in the Buy-In program at any time in calendar year 2004 as indicated in the state eligibility files.

Item 1(a) is presumed to be an unduplicated count of individuals enrolled for the first time. These include individuals who have either never participated in the Buy-In program or have not participated since January 2000. States are not expected to search their enrollment records for dates prior to January 2000.

Item 1(b) defines the *re-enrolled group*. This group reflects the "churning" or turnover rate for this program. "Re-enrolled" individuals are defined as those who had (a) a previous enrollment in the Buy-In program at any time since the inception of the program or since January 2000, whichever is later, (b) became disenrolled, and then (c) enrolled again in the Buy-In program in 2004. (States are not expected to search their enrollment records for dates prior to January 2000.) This includes individuals who first enrolled in 2004. An individual should not be considered "re-enrolled" unless there is an actual gap in Medicaid Buy-In coverage. For example, an individual may be disenrolled but is then re-enrolled retroactive to when they were disenrolled (thus making his or her enrollment continuous). For the purposes of this item, this individual would not be considered re-enrolled.

Item 1(c) refers to the *continuously enrolled group* and reflects those individuals who remain in the Buy-In program for the entire calendar year.

Item 1(d) refers to the *fourth-quarter group*. This group provides a standard count of participants who have been enrolled for a discrete period of time.

Item 1(e) refers to the *longitudinal group*. This group provides a standard approach for tracking how earnings change for participants who have been in the program for at least two quarters in two consecutive years. To be included in this group, individuals do not have to be enrolled continuously between the two quarters.

Item 1(f) refers to the *cumulatively enrolled group*. We recognize that reporting this information will be more difficult for some states than others depending on the program start date. For states whose programs started in 2004, the number in the cumulatively enrolled group will equal the number in the *first-time group*. Going forward, the cumulatively enrolled can be calculated by adding the counts of first-time enrolled in each year. For programs that started prior to 2004, we ask states to determine an unduplicated cumulative count as accurately as possible using available data going back to the program's inception or January 2000, whichever is later.

# Data Element 2: Medicaid Eligibility Status

## A. Wording

2. How many individuals in the **first-time group** were enrolled in Medicaid for at least 30 consecutive days in the 12 months immediately prior to the date they became enrolled in the Buy-In program and in what eligibility group were they enrolled?

(a) Number enrolled in Medicaid for at least 30 days in prior year - sum of 1) thru 6) below (see instruction guide for more information):

1) Receiving cash (including SSI) or eligible under Section 1931:
2) Medically needy:
3) Poverty-related:
4) Other:
5) 1115 demonstration:
6) Medicaid status unknown:

(b) Number not enrolled in Medicaid for at least 30 days in prior year:

(c) Number for whom Medicaid status is undetermined:

(d) Sum of boxes (a), (b), and (c):

(e) Number of first-time enrollees (from Data Element 1(a):

(f) If there is a difference between lines (d) and (e), please explain:

Recommended data source for Element 2: MMIS eligibility file

## B. Instructions

Groups 1) thru 5) above correspond roughly to the Maintenance Assistance Status (MAS) categories as described in the Medicaid Statistical Information System (MSIS). MSIS classifies individuals who are eligible for Medicaid into one of four bases of eligibility (BOE): (1) blind/disabled; (2) child; (3) adult; and (4) aged.

We expect that most Buy-In participants with prior Medicaid coverage were in the blind/disabled BOE group. However, some Buy-In participants may have been in the child, adult, or aged BOE group prior to enrolling in the Buy-In program. Please include these individuals in the appropriate groups 1) thru 5) above. An individual who was classified in more than one MAS group during the 12 months immediately prior to Buy-In enrollment will be included in the most recent group to which he or she belonged.

The instructions below describe the individuals who will be counted under groups 1) thru 5) under 2(a). Table 1 at the end of the instruction guide provides more detail as well as additional

information about where to classify individuals who were not in Medicaid under the blind/disabled BOE.

In determining if an individual is "eligible for Medicaid for at least 30 consecutive days," please account for the following:

- If an individual has been in more than one eligibility group in the designated period, select and record the most recent eligibility group.

- Include those individuals who are eligible to receive services, whether or not they received services.

- Include individuals who may have been enrolled in an 1115 demonstration waiver or any Health Insurance Flexibility and Accountability (HIFA) waiver under group 5) above.

- Do not include any individuals who did not meet their spend-down amount and therefore never become eligible for Medicaid.

- Do not include any State-only funded programs in this group.

Individuals with any variation of SSI payments, including state supplementary payments and payments under the 1619(a) provision, will be counted in line 2(a)1). Adults and children who qualified for Medicaid coverage under Section 1931 of the Act should also be included in line 2(a)1.[1] Former SSI cash recipients receiving Medicaid under Section 1619(b) of the Social Security Act (hereafter, "the Act") should be placed in the "Other" category (i.e., line 2(a)4)).

For Section 209(b) states with no Medically Needy option (e.g., Missouri and Indiana), the mandatory spend-down group should be included under line 2(a)2), the Medically Needy category.

The "Poverty-related" group includes (1) persons covered under optional Medicaid programs that extend benefits to individuals with incomes below a specified income the Federal poverty level and (2) persons who are eligible as QMBs, SLMBs, QIs, and QDWIs (see Table 1 at the end of the instruction guide for more detail).[2] However, individuals who receive SSI benefits should be placed in line 2(a)1) above regardless of whether they qualify as QMBs or SLMBs.

[1] Section 1931 of the Social Security Act requires states to extend Medicaid coverage to parents and children who would have been eligible for Medicaid through the Aid to Families with Dependent Children (AFDC) cash assistance program rules in place in July, 1996, just before federal welfare reform was passed.

[2] Information on QMBs, SLMBs, and QDWIs can be found at: http://www.cms.gov/glossary/ and http://www.cms.hhs.gov/dualeligibles/ftshhmpg.asp

The "Other" group includes individuals such as (1) former SSI cash recipients receiving Medicaid through section 1619(b) of the Act; (2) disabled adult children (DAC) with no SSI; and (3) disabled widows and widowers with no SSI. In addition, this group includes all individuals whose Medicaid status is known but who do not fit into the remaining groups (i.e., groups 1), 2), 3), 5), or 6)).

Item 2(a)6), Medicaid status unknown, and item 2(c), Medicaid status undetermined, are mutually exclusive. The former indicates that an individual is enrolled in Medicaid but the eligibility group is unknown, while the latter indicates that the state could not determine if the individual is enrolled in Medicaid.

# Data Element 3: SSDI Status

## A. Wording

3. How many individuals in the **first-time group** were receiving SSDI benefits at the time of their enrollment in the Buy-In program?

(a) Number receiving SSDI benefits:

(b) Number not receiving SSDI benefits:

(c) SSDI status undetermined:

(d) Sum of boxes (a), (b), and (c):

(e) Number of first-time enrollees (from Data Element 1(a)):

(f) If there is a difference between lines (d) and (e), please explain:

Recommended data source for Element 3: MMIS eligibility file

## B. Instructions

This count only includes individuals receiving SSDI benefits at the time of Buy-In enrollment.

When considering an individual's eligibility to receive SSDI benefits:

- Do not include spouses' SSDI or other Title II benefits.
- Do not include individuals who have not yet been determined eligible to receive SSDI.

If some or all of the SSDI records for your state have been over-written since individuals' time of enrollment, include the new SSDI status and describe this occurrence in item 3(f).

# Data Element 4: Other Health Coverage

## A. Wording

4. How many individuals in the 2004 **fourth-quarter group** also had other health coverage through public or private third-party insurance at any point during the fourth quarter of 2004? In what type of plans were these individuals enrolled?

(a) Number with health coverage in addition to Medicaid:

1) Medicare:
2) Other public plan:
3) Private plan:
4) Other:

(b) Number with only Medicaid:

(c) Sum of boxes (a) and (b):

(d) Number in the fourth-quarter group (from Data Element 1(d)):

(e) If there is a difference between lines (c) and (d), please explain:

Recommended data source for Element 4: MMIS eligibility file

## B. Instructions

This count only reflects coverage that enrollees had during the fourth quarter of 2004.

An "other public plan" is any other government-operated health insurance plan. Examples of entries in item 4(a)2) are CHAMPUS, VA, or other military health insurance plans. An example of 4(a)3) is employer-based insurance, including Blue Cross/Blue Shield plans.

The category of "Other" in line 4(a)4) includes individuals with any other health insurance coverage even if this other insurance coverage is not specified or known.

If individuals have multiple types of coverage, include them in all appropriate lines.

# Data Element 5: Cost Sharing

## A. Wording

5. Of those individuals in the 2004 **fourth-quarter group**, how many were required to pay premiums, coinsurance, or copayments during this time, and what was the average amount?

(a) Number of participants required to pay premiums:

(b) Average monthly premium due for fourth quarter of 2004 for those in 5(a):

(c) Number of participants required to pay coinsurance (i.e., a percentage of the price for a given good or service):

(d) Average monthly coinsurance amount due for fourth quarter of 2004 for those in 5(c):

(e) Number of participants required to pay copayments (i.e., a specific dollar amount for a given good or service):

(f) Average monthly copayments due for fourth quarter of 2004 for those in 5(e):

Recommended data source for Element 5: Billing and collection system

## B. Instructions

Items (a), (c), and (e) are not mutually exclusive.

Count individuals who would be required to pay coinsurance or copayments for services if they would have used services, even though they may not have actually used services during this period.

This item asks for how much was owed, not how much was actually collected. When calculating this dollar amount, please use the following guidelines:

- Subtract any refunds due back to individuals because of disenrollment or any other reason.
- Do not count premiums past due during, but not for, the fourth quarter.

Coinsurance is defined as paying a specific percentage of costs for a service, visit, or episode of treatment. Copayment is defined as paying a specific dollar amount per service, visit, or episode of treatment.

5(b), 5(d) and 5(f) should be calculated as follows: take the total amount of premiums (or coinsurance or copayment amounts, as appropriate) for the fourth quarter, divide by the number of participants required to pay a premium (5(a)), coinsurance (5(c)), or copayment (5(e)), then

divide the result by 3. For example, an individual who had a three-month premium history of $15, $0, and $10 would have an average monthly premium of $8.33, not $12.50.

We only want cost-sharing payment information (premiums, copayments, and coinsurance) specific to the Medicaid Buy-In, not to the state's Medicaid program in general. If the state requires all Medicaid enrollees to pay a pharmacy copayment, do not include it here. If the pharmacy copayment is only applicable to the Buy-In, do include those individuals and the amount.

# Data Element 6: Fourth-Quarter UI Earnings

## A. Wording

6. What were the monthly UI earnings for individuals in the 2004 **fourth-quarter group** during the fourth quarter of 2004?

(a) Total UI earnings for the 2004 fourth-quarter group for the **entire fourth quarter** of 2004:

(b) Number of individuals with **monthly** UI earnings (rather than quarterly earnings) in the following categories during the fourth quarter of 2004:

1) $0 reported (or earnings not reported in UI system for the entire fourth quarter of 2004)
2) $1 – 200
3) $201 – 400
4) $401 – 600
5) $601-800
6) $801-810
7) $811-1,000
8) $1,001-1,200
9) $1,201-1,400
10) $1,401-1,600
11) $1,601-1,800
12) $1801-2,000
13) $2,001+

(c) Number **without** monthly UI earnings during the fourth quarter of 2004 – box 1) above:

(d) Number **with** monthly UI earnings during the fourth quarter of 2004 – sum of 2) thru 13) above:

(e) Sum of (c) and (d):

(f) Number in the fourth-quarter group (from Data Element 1(d)):

(g) If there is a difference between lines (e) and (f), please explain below:

Recommended data source for Element 6: Unemployment Insurance System
**NOTE:** If sources instead of, or in addition to, the UI system are used to report this data element, we will be unable to report these data.

## B. Instructions

States should use their unemployment insurance (UI) systems to identify quarterly earnings. As noted above, if data sources instead of, or in addition to, the UI system are used to report this data element, we will be unable to report these data because of the inconsistency in the data source.

For item 6(a), sum the UI earnings **for the entire fourth quarter** across all individuals in the group.

For item 6(b), (1) calculate total earnings for each individual by identifying the individual's earnings for the entire fourth quarter; (2) divide by three; and (3) present the frequency distribution of individuals in the various earnings categories.

Do not include self-employment earnings (Data Element 6A contains self-employment earnings information).

Please note that item 6(b)1) should include (1) individuals with UI earnings of $0; and (2) individuals who are not in the UI system for the entire fourth quarter of 2004. As a result, the sum of element 6(c) and 6(d) should equal the total number of individuals in the fourth-quarter group in element 6(f). If it does not, please explain why.

# Data Element 6A: Self-Employment Earnings

## A. Wording

OPTIONAL - For those states that can report self-employment data, please answer the following question:

6A. How much did the **fourth-quarter group** earn through self-employment?

(a) Total self-employment earnings for the **entire fourth quarter** of 2004:

(b) Number of individuals with **monthly** self-employment earnings (rather than quarterly earnings) in the following categories during the fourth quarter of 2004:

1) $0 reported (or earnings not reported in UI system for the entire fourth quarter of 2004)
2) $1 – 200
3) $201 – 400
4) $401 – 600
5) $601-800
6) $801-810
7) $811-1,000
8) $1,001-1,200
9) $1,201-1,400
10) $1,401-1,600
11) $1,601-1,800
12) $1,801-2,000
13) $2,001+

(c) Number **without** monthly self-employment earnings during the fourth quarter of 2004 – box 1) above:

(d) Number **with** monthly self-employment earnings during the fourth quarter of 2004 – sum of 2) thru 13) above:

(e) Sum of (c) and (d):

(f) Number in the fourth-quarter group (from Data Element 1(d)):

(g) If there is a difference between lines (e) and (f), please explain below:

Recommended data source for Element 6A: MMIS eligibility file

## B. Instructions

States should use the eligibility system to determine self-employment earnings. Use earnings before taxes.

For item 6A(a), sum the total fourth quarter self-employment earnings across all individuals in the group.

For item 6A(b), (1) calculate total self-employment earnings for each individual by identifying the individual's earnings for the quarter; (2) divide each individual's earnings by three; (3) present the frequency distribution of individuals in the various earnings categories.

# Data Element 7: Change in UI Earnings Over Time

## A. Wording

7. For individuals in the **longitudinal group**, what were average monthly UI earnings in the fourth quarter of 2004 as compared with average monthly UI earnings in the fourth quarter of 2003?

(a) Total UI earnings for fourth quarter of 2003 or 2004:

(b) Percent change from 2003 to 2004:

(c) Number of individuals with **monthly** UI earnings (rather than quarterly earnings) in the following categories during the fourth quarter of 2003 or 2004:

1) $0 reported (or earnings not reported in UI system for the entire fourth quarter of the given year).
2) $1 – 200
3) $201 – 400
4) $401 – 600
5) $601-800
6) $801-810
7) $811-1,000
8) $1,001-1,200
9) $1,201-1,400
10) $1,401-1,600
11) $1,601-1,800
12) $1,801-2,000
14) $2,001+

(d) Number **without** monthly UI earnings during the fourth quarter of 2003 or 2004 – box 1) above:

(e) Number **with** monthly UI earnings during the fourth quarter of 2003 or 2004 – sum of 2) thru 13) above:

(f) Sum of (d) and (e):

(g) Number in the longitudinal group (from Data Element 1(e)):

(h) If there is a difference between lines (f) and (g), please explain below:

Recommended data source for Element 6: Unemployment Insurance System
**NOTE:** If sources instead of, or in addition to, the UI system are used to report this data element, we will be unable to report these data.

## B. Instructions

This data element should only be completed by states that had Buy-In programs that were operational as of October 1, 2003.

States should use their unemployment insurance (UI) systems to collect quarterly earnings and divide the earnings by 3 before entering the frequency distribution across earnings categories. As noted above, if data sources instead of, or in addition to, the UI system are used to report this data element, we will be unable to report these data because of the inconsistency in the data source.

We recognize that the UI system does not capture self-employment. We also recognize that participants in the longitudinal group may have reported earnings in one year but not the other. These individuals should still be included in the counts. In the year in which the individual has no reported earnings, he or she should be counted in line 7(c)1).

# Data Element 8: Medicaid Expenditures

## A. Wording

8. For individuals in the 2004 **fourth-quarter group**, what was the average per member per month Medicaid expenditure for the time spent in the Buy-In during 2004?

(a) Average per member per month expenditure in 2004:

(b) Number of individuals with average monthly expenditures in the following ranges:

1) $0
2) $1 – 500
3) $501 – 1,000
4) $1,001 - 5,000
5) $5,001 - 20,000
6) $20,001+

(c) Sum of 1) thru 6):

(d) Number in the fourth-quarter group (from Data Element 1(d)):

(e) If there is a difference between lines (c) and (d), please explain:

Recommended data source for Element 8: MMIS claims files

**NOTE:** 8(a) and 8(b) use different methods to calculate average expenditures (see instructions).

## B. Instructions

Item 8(a) should be calculated by:

(1) Summing payments on all claims for all individuals across the selected months (i.e., the months in 2004 during which the individuals were enrolled in the Buy-In program),

(2) Adding the total number of enrollment months (i.e., the number of months during which individuals were enrolled in the Buy-In program),

(3) Dividing the sum of all payments by the sum of total number of enrollment months.

Item 8(b), the average monthly expenditure, is calculated by:

(1) Summing payments on all claims for each individual across the selected months (i.e. the months in 2004 during which the individual was enrolled in the Buy-In program),

(2) Dividing by the number of months to obtain a monthly average for each individual, and

(3) Calculating the frequency of individual monthly averages in the given ranges.

When calculating this element, please use the following guidelines:

- Include the total Medicaid costs (State and Federal dollars) for all Medicaid services, including waiver services.
- Include the monthly capitation payment for individuals enrolled in managed care programs (if applicable).
- Include those individuals in the average that had no services.
- Include the amount paid, not the amount billed.
- Do not include administrative costs.
- Do not include premiums paid for third-party insurance or Medicare.

TABLE 1

DEFINITIONS OF MEDICAID ELIGIBILITY GROUPS IN DATA ELEMENT 2

| Category | Description of Individuals | Individuals' Basis of Eligibility (BOE)[a] |
|---|---|---|
| **Receiving cash (including SSI) or eligible under Section 1931—line 2(a)1)** | | |
| | Individuals receiving any variation of SSI payments, including reduced SSI payments under section 1619(a) of the Act.<br>**NOTE:** Former SSI cash recipients receiving Medicaid under section 1619(b) of the Act should be placed in the "Other" category below. | Blind/disabled<br>Aged |
| | Individuals receiving state supplementary payments. | Blind/disabled<br>Aged |
| | Children in families with low income who are qualified to receive Medicaid under Section 1931 of the Act.[b] | Children |
| | Adults deemed essential for the well being of a child qualified for Medicaid under Section 1931 of the Act as well as pregnant women with no other eligible children.[b] | Adults |
| **Medically needy—line 2(a)2)** | | |
| | Individuals with income below state medically needy income levels or individuals who "spend down" to medically needy income levels by subtracting medical expenditures from their income.<br>**NOTE:** For section 209(b) states with no medically needy option (e.g., Missouri and Indiana), the mandatory spend-down group should be included in this line. | Blind/disabled<br>Aged<br>Children<br>Adults |
| **Poverty-related—line 2(a)3)** | | |
| | **NOTE:** Individuals who receive SSI benefits should be placed in line 2(a)1) above regardless of whether they qualify as QMBs or SLMBs. | |
| | Qualified Medicare Beneficiaries (QMBs) who are entitled to Medicare Part A, whose income does not exceed 100% of the Federal poverty level, and whose resources do not exceed twice the SSI standard.[c] | Blind/disabled<br>Aged |
| | Specified Low-Income Medicare Beneficiaries (SLMBs) who meet all of the eligibility requirements for QMB status, except with income in excess of the QMB income limit, but not exceeding 120% of the Federal poverty level.[c] | Blind/disabled<br>Aged |
| | Qualifying Individuals (QIs) having higher income than allowed for QMBs or SLMBs.[c] | Blind/disabled<br>Aged |
| | Qualified Disabled Working Individuals (QDWIs) who are entitled to Medicare Part A.[c] | Blind/disabled<br>Aged |
| | Individuals with income below the poverty level and resources within state limits who are entitled to full Medicaid benefits. | Blind/disabled<br>Aged |
| | Pregnant women with incomes at or below 133% of the FPL, or higher income thresholds elected by the state. | Adults |
| | Women under age 65 who are found to have breast or cervical cancer, or have precancerous conditions. | Adults |
| | Children and adults made eligible by a Title XXI Medicaid expansion under the State Children Health Insurance Program (SCHIP). | Children<br>Adults |

| Category | Description of Individuals | Individuals' Basis of Eligibility (BOE)[a] |
|---|---|---|
| | Children, pregnant women, and caretaker relatives made eligible under the more liberal income and resource requirements as authorized under section 1902(r)(2) of the Act when used to disregard income on a poverty-level-related basis. | Children<br>Adults |
| **Other Medicaid eligibles—line 2(a)4)** | | |
| | This group includes (1) former SSI cash recipients receiving Medicaid through section 1619(b) of the Act; (2) disabled adult children (DAC) with no SSI; and (3) disabled widows and widowers with no SSI. | Blind/disabled |
| | This group also includes all individuals with Medicaid coverage for at least 30 consecutive days during the 12 months immediately prior to Buy-In enrollment whose Medicaid eligibility status is known and who are not classified in the other groups in this table. | Blind/disabled<br>Aged<br>Children<br>Adults |
| **1115 Demonstration—line 2(a)5)** | | |
| | Individuals made eligible under the authority of the following should be included in this group: (1) a section 1115 demonstration waiver due to poverty-level-related expansions; or (2) the Health Insurance Flexibility and Accountability (HIFA) demonstration initiative. | Blind/disabled<br>Aged<br>Children<br>Adults |
| **Medicaid status unknown—line 2(a)6)** | | |
| | This group includes all individuals known to have Medicaid coverage for at least 30 consecutive days during the 12 months immediately prior to Buy-In enrollment but whose Medicaid eligibility group is unknown. | Blind/disabled<br>Aged<br>Children<br>Adults |

[a]Medicaid has four types of participants, or bases of eligibility (BOE), which are (1) blind/disabled; (2) aged; (3) children; and (4) adults.

[b]Section 1931 of the Act requires states to extend Medicaid coverage to parents and children who would have been eligible for Medicaid through the Aid to Families with Dependent Children (AFDC) 1996 income thresholds.

[c]Information on QMBs, SLMBs, QI1s, QI2s, and QDWIs can be found at: http://www.cms.gov/glossary/ and http://www.cms.hhs.gov/dualeligibles/ftshhmpg.asp

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# APPENDIX C

# STATE DATA SOURCES FOR COMPLETING THE ANNUAL BUY-IN REPORT

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TABLE C.1

SOURCES OF DATA USED TO COMPLETE STATE ANNUAL REPORT FORM, 2004

| State Recommended Source | Data Element 1 MMIS eligibility file | Data Element 2 MMIS eligibility file | Data Element 3 MMIS eligibility file | Data Element 4 MMIS eligibility file | Data Element 5 Billing and Collection System | Data Element 6 Unemployment Insurance System | Data Element 6A MMIS eligibility file | Data Element 7 Unemployment Insurance System | Data Element 8 MSIS claims files |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | |
| Alaska | MMIS eligibility file | MMIS eligibility file | EIS eligibility file | Billing and Collection | Billing and Collection | Unemployment Insurance System | | Unemployment Insurance System | MMIS claims files |
| Arkansas | Arkansas Client Eligibility File | Arkansas Client Eligibility File | Arkansas Client Eligibility File | | Decision Support System (MMIS) | Unemployment Insurance System | | Unemployment Insurance System | Decision Support System (MMIS) |
| California | MMIS eligibility file | MMIS eligibility file | MMIS eligibility file | MMIS eligibility file | MMIS eligibility file | Unemployment Insurance System | | Unemployment Insurance System | MMIS claims file |
| Connecticut | MMIS eligibility file | MMIS eligibility file | MMIS eligibility file | MMIS eligibility file | Billing and Collection | Unemployment Insurance System | MMIS eligibility files | Unemployment Insurance System | MMIS claims files |
| Illinois | MMIS eligibility file | MMIS eligibility file | MMIS eligibility file | MMIS eligibility file | Billing and Collection | Unemployment Insurance System | | Unemployment Insurance System | MMIS claims files |
| Indiana | ICES eligibility file | ICES eligibility file | ICES eligibility file | ICES eligibility file and Claims | Claims and Buy-In Vendor | Unemployment Insurance System | ICES eligibility system | | AIM claims and Eligibility |
| Iowa | MMIS eligibility file | MMIS eligibility file | MMIS eligibility file | MMIS eligibility file | Billing and collection system | Unemployment Insurance System | | Unemployment Insurance System | MMIS claims files |
| Kansas | MMIS eligibility file | MMIS eligibility file | KS Automated Eligibility Child Support Enforcement System (KAECSES) | MMIS eligibility file | Billing & Collections System | Unemployment Insurance System | MMIS eligibility file & KAECSES | Unemployment Insurance System | MMIS claims files |
| Louisiana | Medicaid Data Warehouse (MDW) | MDW | Medicaid Eligibility Determination System (MEDS) | MDW/ MEDS | Billing & Collections System | Unemployment Insurance System | MEDS | | MDW |
| Maine | MMIS eligibility file | MMIS eligibility file | Maine Automated Client Eligibility System | | MMIS claims file; premium data file | Unemployment Insurance System | | Unemployment Insurance System | MMIS claims files |

TABLE C.1 (*continued*)

| State Recommended Source | Data Element 1 MMIS eligibility file | Data Element 2 MMIS eligibility file | Data Element 3 MMIS eligibility file | Data Element 4 MMIS eligibility file | Data Element 5 Billing and Collection System | Data Element 6 Unemployment Insurance System | Data Element 6A MMIS eligibility file | Data Element 7 Unemployment Insurance System | Data Element 8 MSIS claims files |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | |
| Massachusetts | MMIS eligibility file | MMIS eligibility data | MMIS eligibility data | MMIS eligibility data | Billing and Collection System | Unemployment Insurance System (Mass. DOR) | | Unemployment Insurance System (Mass. DOR) | MMIS Claims Files |
| Michigan | MDCH Bi-Query Data Warehouse Tera Data | MDCH Bi-Query Data Warehouse Tera Data | MDCH Bi-Query Data Warehouse Tera Data | MDCH Bi-Query Data Warehouse Tera Data | MDCH Bi-Query Data Warehouse Tera Data | | | | MDCH Bi-Query Data Warehouse Tera Data |
| Minnesota | MMIS Eligibility File | MMIS Eligibility File | PA Eligibility File | MMIS Eligibility File | Billing and Collection System | Unemployment Insurance System | PA Eligibility File | Unemployment Insurance System | MMIS Claims Files |
| Missouri | Income Maintenance Eligibility File | Income Maintenance Eligibility File and SDX (SSI) File | Income Maintenance Eligibility File | MMIS eligibility file | Income Maintenance Eligibility File | Employment Security File[a] | | Employment Security File[a] | Medicaid Paid Claims File |
| Nebraska | NFOCUS eligibility system | Advantage eligibility file | NFOCUS income tables | TPL subsystem | Program staff | SEW file interface in NFOCUS[a] | | SEW file interface in NFOCUS[a] | Advantage |
| New Hampshire | MMIS eligibility file | MMIS eligibility file | MMIS eligibility file | MMIS eligibility file | Billing and Collection | Unemployment Insurance System | MMIS eligibility files | Unemployment Insurance System | MSIS claims files |
| New Jersey | MMIS eligibility file | Recipient History Master File | Dept. of Medical Assistance & Health Services (DMAHS) database. | TPL Resource File | | NJ Wage Record System[a] | | NJ Wage Record System[a] | MMIS Electronic Files |
| New Mexico | MMIS eligibility file | MMIS eligibility file | MMIS eligibility file | MMIS eligibility file | | Unemployment Insurance System | MMIS eligibility file | Unemployment Insurance System | MMIS Claims Files |
| New York | DOH/ OMM AFPP Data Mart | DOH/ OMM AFPP Data Mart | DOH/ OMM AFPP Data Mart | DOH/ OMM AFPP Data Mart | | NY Dept. of Taxation and Finance[a] | | NY Dept. of Taxation and Finance[a] | DOH/ OMM AFPP Data Mart |
| North Dakota | Vision System | Vision and TECS System | Vision System | Vision System | Vision System | TECS | Vision System | TECS | Vision System |
| Oregon | MMIS Eligibility file | MMIS Eligibility | SSA BENDEX | MMIS Eligibility file | EPD Office of Financial Statistics Monthly | Unemployment Insurance System | | Unemployment Insurance System | MMIS Claims Files |

TABLE C.1 (*continued*)

| State Recommended Source | Data Element 1 MMIS eligibility file | Data Element 2 MMIS eligibility file | Data Element 3 MMIS eligibility file | Data Element 4 MMIS eligibility file | Data Element 5 Billing and Collection System | Data Element 6 Unemployment Insurance System | Data Element 6A MMIS eligibility file | Data Element 7 Unemployment Insurance System | Data Element 8 MSIS claims files |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | |
| Pennsylvania | Client Information System(CIS) | CIS, Data Warehouse (DW) | CIS | CIS | CIS | CIS, Unemployment Insurance System | CIS, Unemployment Insurance System | CIS, Unemployment Insurance System | Data Warehouse, Claims Files |
| South Carolina | Medicaid Eligibility Determination System | Medicaid Eligibility Determination System | Medicaid Eligibility Determination System | Medicaid Eligibility Determination System | Medicaid Eligibility Determination System | Employment Security Commission (ESC) Benefit Match[a] | Medicaid Eligibility Determination System | ESC Benefit Match[a] | Medicaid Eligibility Determination System |
| Utah | MMIS eligibility file | MMIS eligibility file | MMIS eligibility file | MMIS eligibility file | MMIS eligibility file | Unemployment Insurance System | PACMIS | Unemployment Insurance System | MMIS claims files |
| Vermont | MMIS eligibility file | MMIS eligibility file | MMIS eligibility file | MMIS eligibility file | Billing and Collection | Unemployment Insurance System | MMIS eligibility files | Unemployment Insurance System | MMIS claims files |
| Washington | Automated Client Eligibility System (ACES) | ACES/Monthly SDX/503 LEADS | ACES Unearned Income | TPL Medicare; MMIS | Office of Financial Recovery | Unemployment Insurance System | ACES Earned Income Records | Unemployment Insurance System | MMIS (ticket to Work File) |
| West Virginia | HWT IQ Safeguard | HWT IQ Safeguard | RAPIDS | UNISYS | PCG | RAPIDS[a] | RAPIDS | RAPIDS[a] | HWT IQ Safeguard |
| Wisconsin | MMIS eligibility file | MMIS eligibility file | CARES (Client Assistance for Re-employment and Economic Support System | MMIS eligibility file | MMIS eligibility file | Unemployment Insurance System | | Unemployment Insurance System | MMIS claims |

[a]This is the unemployment insurance (UI) system in this state or, for West Virginia, contains data from the UI system.

TABLE C.2

DATA SUBMITTED FOR 2004 ANNUAL BUY-IN REPORTS

| State | Report Submitted | Basic Info | Data Element 1 | Data Element 2 | Data Element 3 | Data Element 4 | Data Element 5 | Data Element 6 | Data Element 6A (Optional) | Data Element 7 | Data Element 8 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Alaska | | | | | | | | | N/S | | |
| Arkansas | | | | | | N/S | | | N/S | | |
| California | | | | | | | | | | N/S | |
| Connecticut | | | | | | | | | | | |
| Illinois | | | | | | | | | N/S | | ✓ |
| Indiana | | | | | | | | | | N/S | |
| Iowa | | | | | | | | | N/S | | |
| Kansas | | | | | | | | | | | |
| Louisiana | | | | | | | | | | N/A | |
| Maine | | | | | | N/S | | | N/S | | |
| Massachusetts | | | | | | | | | N/S | | |
| Michigan | | | | | | | | N/S | N/S | N/A | |
| Minnesota | | | | | | | | | | | |
| Missouri | | | | | | | | | N/S | | |
| Nebraska | | | | | | | | | ✓ | | |
| New Hampshire | | | | | | | | | | | |
| New Jersey | | | | | | | | ✓ | N/S | ✓ | |
| New Mexico | | | | | | | N/S | | | | |
| New York | | | | ✓ | | | | | N/S | | |
| North Dakota | | | | | | ✓ | | | | N/A | |
| Oregon | | | | | | | | | N/S | | |
| Pennsylvania | | | | ✓ | | | | | N/S | ✓ | |
| South Carolina | | | | | | | | | | | |
| Utah | | | | | | | | | | | |
| Vermont | | | | | | | | | | | |
| Washington | | | | | | | | | | | |
| West Virginia | | | | | | | | | | N/A | |
| Wisconsin | | | | | | | | | N/S | | |

Note: Blank cells indicate that item was completed. ✓ indicates incomplete items.

N/S = not submitted
N/A = not applicable because the program did not exist in 2003.

# APPENDIX D

# SUPPORTING TABLES

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**Table D.1: Summary of Buy-In Enrollment and Participant Characteristics, by State, 2004**

| | Enrollment as of December 2004 | % in Medicaid prior to Buy-In Enrollment[a] | % with SSDI at Buy-In Enrollment[b] | % Dually Enrolled in Medicare[c] | Average Monthly Earnings ($) | Average Monthly Premium[d] | Average PMPM Medicaid Expenditures ($) |
|---|---|---|---|---|---|---|---|
| Alaska | 194 | 63 | 56 | 77 | 1,404 | 35 | 1,041 |
| Arkansas | 48 | 41 | 29 | N/S | 1,014 | 0 | 535 |
| California | 1,165 | 91 | 85 | 89 | 951 | 31 | 770 |
| Connecticut | 3,365 | 92 | 80 | 84 | 770 | 37 | 1,178 |
| Illinois | 656 | 60 | 81 | 78 | 732 | 51 | 709 |
| Indiana | 6,117 | 79 | - | 69 | 699 | 74 | 2,657 |
| Iowa | 7,695 | 63 | 85 | 86 | 500 | 39 | 835 |
| Kansas | 823 | 69 | 97 | 91 | 514 | 71 | 866 |
| Louisiana | 424 | 42 | 57 | 50 | 918 | 77 | 577 |
| Maine | 644 | 86 | 84 | N/S | 861 | 13 | 823 |
| Massachusetts | 7,520 | 84 | 57 | 65 | 1,211 | 47 | 582 |
| Michigan | 140 | 100 | 91 | 94 | N/S | 0 | 454 |
| Minnesota | 6,165 | 73 | 83 | 91 | 640 | 56 | 1,725 |
| Missouri | 18,610 | 30 | 71 | 76 | 579 | 69 | 1,045 |
| Nebraska | 67 | 91 | 100 | 92 | 762 | 101 | 700 |
| New Hampshire | 1,268 | 72 | 78 | 82 | 720 | 37 | 1,382 |
| New Jersey | 1,351 | 55 | 50 | 54 | 897 | 0 | 783 |
| New Mexico | 1,181 | 64 | 63 | 37 | 1,369 | 0 | 892 |
| New York | 2,480 | 76 | 80 | 76 | 699 | 0 | 1,189 |
| North Dakota | 258 | 45 | 77 | - | 450 | 58 | 2,136 |
| Oregon | 583 | 82 | 95 | 86 | 895 | 103 | 697 |
| Pennsylvania | 4,865 | 100 | 60 | 57 | 865 | 46 | 950 |
| South Carolina | 52 | 79 | 26 | 40 | 1,531 | 0 | 1,077 |
| Utah | 260 | 86 | 68 | 80 | 567 | 162 | 1,348 |
| Vermont | 520 | 89 | 93 | 89 | 716 | 0 | 982 |
| Washington | 448 | 63 | 86 | 80 | 724 | 86 | 589 |
| West Virginia | 90 | 38 | 9 | 10 | 1,179 | 26 | 862 |
| Wisconsin | 7,713 | 75 | - | 86 | 522 | 143 | 1,010 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Total** | **74,702** | **65** | **73** | **76** | **766** | **56** | **1,157** |

Source: State Annual Buy-In Reports for 2004.

Note: Data for enrollment in Medicaid and SSDI are for individuals who enrolled in the Buy-In program for the first time in 2004. Data for enrollment in Medicare, earnings, premiums, and Medicaid expenditures are for individuals enrolled for the entire fourth quarter of 2004.

[a]Personnel in Pennsylvania noted that their 2004 data may be inaccurate. Information from a new data system that New York began using in 2005 suggests that the system from which the information above was drawn may have undercounted the number of New York Buy-In participants enrolled in the Medicaid poverty-related category prior to Buy-In enrollment (see note to Table V.1 for a definition of the poverty-related category). This suggests that New York's proportion enrolled in Medicaid prior to Buy-In enrollment may be an underestimate of the true proportion.

[b]Data for Indiana were excluded because the state could not determine SSDI status for enrollees who were not in Medicaid immediately prior to Buy-In enrollment. Data for Wisconsin were excluded because the state was unable to determine SSDI status for approximately one-third of its new participants.

[c]North Dakota was excluded because the state's data were inaccurate.

[d]Average calculated among premium payers. States with zero values did not have any fourth-quarter participants who were required to pay a premium.

PMPM = per member per month
N/S = not submitted

**Table D.2: Number of Participants in the Medicaid Buy-In Program in Selected Enrollment Groups, by State, 2002-2004**

| | First-time Group | | | Re-enrolled Group | | | Continuously Enrolled Group | | | Fourth-quarter Group | | | Longitudinal Group | | | Cumulatively Enrolled Group | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | N | | | N | | | N | | | N | | | N | | | N | | |
| State | 2002 | 2003 | 2004 | 2002 | 2003 | 2004 | 2002 | 2003 | 2004 | 2002 | 2003 | 2004 | 2002 | 2003 | 2004 | 2002 | 2003 | 2004 |
| Alaska | 131 | 129 | 134 | 6 | 39 | 33 | 65 | 83 | 95 | 186 | 179 | 173 | 79 | 66 | 90 | 338 | 540 | 619 |
| Arkansas | N/S[c] | N/S[c] | 17 | N/S[c] | N/S[c] | 2 | N/S[c] | N/S[c] | 33 | N/S[c] | N/S[c] | 45 | N/S[c] | N/S[c] | 28 | N/S[c] | N/S[c] | 269 |
| California | 403 | 471 | 681 | 66 | 56 | 132 | 384 | 492 | 630 | 651 | 807 | 1,085 | 310 | 453 | 550 | 1,205 | 1,680 | 2,369 |
| Connecticut | 1,534 | 1,285 | 1,265 | 342 | 754 | 706 | 1,245 | 1,536 | 1,796 | 2,075 | 2,505 | 2,940 | 905 | 1,450 | 1,783 | 3,829 | 5,114 | 6,866 |
| Illinois | 421 | 381 | 274 | 10 | 47 | 87 | 5 | 173 | 271 | 177 | 446 | 558 | N/A[b] | 114 | 300 | 421 | 803 | 1,077 |
| Indiana | 4,297 | 3,702 | 3,129 | 30 | 4,297 | 584 | N/A[a] | 2,534 | 3,908 | 2,344 | 5,006 | 5,899 | N/A[b] | 1,803 | 3,598 | 4,297 | 7,999 | 11,457 |
| Iowa | 2,253 | 2,238 | 2,559 | 303 | 382 | 530 | 3,067 | 4,438 | 5,520 | 4,811 | 6,169 | 7,540 | 2,729 | 4,057 | 5,164 | 6,625 | 8,864 | 11,440 |
| Kansas | 516 | 355 | 331 | 4 | 19 | 33 | N/A[a] | 400 | 527 | 384 | 621 | 782 | N/A[b] | 305 | 481 | 516 | 880 | 1,213 |
| Louisiana | N/A[a] | N/A[a] | 522 | N/A[a] | N/A[a] | 6 | N/A[a] | N/A[a] | 31 | N/A[a] | N/A[a] | 385 | N/A[b] | N/A[b] | N/A[b] | N/A[a] | N/A[a] | 522 |
| Maine | 451 | 435 | 353 | 76 | 363 | 157 | 379 | 472 | 316 | 617 | 733 | 591 | 320 | 449 | 294 | 1,696 | 2,128 | 2,510 |
| Massachusetts | 3,777 | 3,349 | 3,098 | 466 | 909 | 2,452 | 3,588 | 4,127 | 3,454 | 5,918 | 6,253 | 6,521 | 3,237 | 3,316 | 3,891 | 12,554 | 16,599 | 19,711 |
| Michigan | N/A[a] | N/A[a] | 125 | N/A[a] | N/A[a] | 0 | N/A[a] | N/A[a] | N/A[a] | N/A[a] | N/A[a] | 84 | N/A[b] | N/A[b] | N/A[b] | N/A[a] | N/A[a] | 125 |
| Minnesota | 1,706 | 1,862 | 1,376 | 799 | 798 | 896 | 4,447 | 4,718 | 4,594 | 5,932 | 6,178 | 5,731 | 4,389 | 4,503 | 4,442 | 10,948 | 11,712 | 14,075 |
| Missouri | 8,122 | 8,781 | 7,446 | 11 | 195 | 320 | N/A[a] | 8,080 | 11,604 | 4,736 | 13,678 | 17,126 | N/A[b] | 3,925 | 10,429 | 8,122 | 16,903 | 24,349 |
| Nebraska | 47 | 44 | 64 | 10 | 9 | 9 | 59 | 77 | 86 | 91 | 102 | 125 | 51 | 60 | 71 | 257 | 303 | 375 |
| New Hampshire | 1,084 | 510 | 616 | 43 | 96 | 228 | N/A[a] | 778 | 715 | 880 | 1,110 | 1,027 | N/A[b] | 654 | 665 | 1,084 | 1,644 | 2,277 |
| New Jersey | 419 | 543 | 678 | 9 | 27 | 58 | 251 | 508 | 816 | 516 | 892 | 1,276 | 169 | 377 | 726 | 723 | 1,561 | 2,081 |
| New Mexico | 630 | 731 | 876 | 23 | 49 | 31 | 301 | 410 | 578 | 712 | 890 | 1,155 | 217 | 322 | 440 | 1,195 | 2,194 | 3,083 |
| New York | N/A[a] | 672 | 2,141 | N/A[a] | 0 | 651 | N/A[a] | N/A[a] | 917 | N/A[a] | 617 | 2,597 | N/A[b] | N/A[b] | 551 | N/A[a] | 672 | 2,813 |
| North Dakota | N/A[a] | N/A[a] | 277 | N/A[a] | N/A[a] | 92 | N/A[a] | N/A[a] | N/A[a] | N/A[a] | N/A[a] | 207 | N/A[b] | N/A[b] | N/A[b] | N/A[a] | N/A[a] | 277 |
| Oregon | 291 | 338 | 160 | 47 | 74 | 64 | 326 | 346 | 407 | 531 | 565 | 543 | 299 | 320 | 396 | 993 | 1,331 | 1,513 |
| Pennsylvania | 1,476 | 1,815 | 1,026 | 72 | 353 | 500 | 7 | 997 | 1,388 | 888 | 2,196 | 3,721 | N/A[b] | 776 | 1,558 | 1,476 | 3,291 | 4,317 |
| South Carolina | N/S[c] | N/S[c] | 19 | N/S[c] | N/S[c] | 2 | N/S[c] | N/S[c] | 40 | N/S[c] | N/S[c] | 50 | N/S[c] | N/S[c] | 38 | N/S[c] | N/S[c] | 116 |
| Utah | 265 | 229 | 263 | 89 | 136 | 167 | 51 | 45 | 72 | 138 | 118 | 168 | 31 | 55 | 65 | 463 | 694 | 964 |
| Vermont | 298 | 265 | 285 | 127 | 145 | 180 | 153 | 223 | 238 | 336 | 385 | 443 | 141 | 197 | 225 | 942 | 1,204 | 1,489 |

| | First-time Group | | | Re-enrolled Group | | | Continuously Enrolled Group | | | Fourth-quarter Group | | | Longitudinal Group | | | Cumulatively Enrolled Group | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | N | | | N | | | N | | | N | | | N | | | N | | |
| State | 2002 | 2003 | 2004 | 2002 | 2003 | 2004 | 2002 | 2003 | 2004 | 2002 | 2003 | 2004 | 2002 | 2003 | 2004 | 2002 | 2003 | 2004 |
| Washington | 142 | 122 | 258 | 15 | 6 | 33 | 5 | 123 | 180 | 136 | 208 | 369 | N/A | 99 | 145 | 142 | 277 | 551 |
| West Virginia | N/A[a] | N/A[a] | 86 | N/A[a] | N/A[a] | 0 | N/A[a] | N/A[a] | N/A[a] | N/A[a] | N/A[a] | 49 | N/A[b] | N/A[b] | N/A[b] | N/A[a] | N/A[a] | 86 |
| Wisconsin | 2,722 | 2,759 | 3,228 | 250 | 412 | 639 | 1,424 | 3,201 | 4,706 | 3,339 | 5,165 | 7,092 | 1,194 | 2,751 | 4,248 | 5,762 | 8,879 | 11,725 |
| Total | 30,985 | 31,016 | 31,287 | 2,798 | 9,166 | 8,592 | 15,757 | 33,761 | 42,922 | 35,398 | 54,823 | 68,282 | 14,071 | 26,052 | 40,178 | 63,588 | 95,272 | 128,269 |

Source: State Annual Buy-In Report Form for 2002, 2003, and 2004.

Note: The **First-time Group** is an unduplicated count of individuals enrolled for the first time in the Medicaid Buy-In Program in a given year (that is, either 2002, 2003, or 2004). The **Re-enrolled Group** are those individuals who had a previous enrollment in the Buy-In program at any time since the inception of the program, became disenrolled, and then enrolled again in the Buy-In program in a given year. The **Continuously Enrolled Group** reflects those individuals who remained on the Buy-In for the entire calendar year. The **Fourth-quarter Group** provides a standard count of participants who have been enrolled for the entire fourth quarter of the given year. The **Longitudinal Group** for a given year provides a count of individuals enrolled in the Buy-In program for the entire fourth quarter of that year and for the entire fourth quarter of the previous year. The **Cumulative Group** contains an unduplicated count of individuals enrolled in the Buy-In Program from its inception to the end of the given calendar year.

[a] Program did not exist until after calendar year ended.
[b] Program did not exist in both the fourth quarter of the given calendar year and of the previous calendar year.
[c] Program existed in the given calendar year but the state did not have a Medicaid Infrastructure Grant and thus did not submit data.

N/A = not applicable
N/S = not submitted

**Table D.3: Total Quarterly Enrollment in the Medicaid Buy-In, 2000-2004, by State**

| | 2000 | | | | 2001 | | | | 2002 | | | | 2003 | | | | 2004 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| State | Mar | Jun | Sep | Dec | Mar | Jun | Sep | Dec | Mar | Jun | Sep | Dec | Mar | Jun | Sep | Dec | Mar | Jun | Sep | Dec |
| Alaska | 38 | 56 | 67 | 77 | 90 | 108 | 113 | 118 | 128 | 143 | 155 | 162 | 164 | 179 | 185 | 192 | 206 | 204 | 222 | 194 |
| Arizona | | | | | | | | | | | | | 145 | 236 | 321 | 395 | 432 | 482 | 565 | 622 |
| Arkansas | | | | | 170 | 183 | 188 | 186 | 97 | 70 | 64 | 65 | 58 | 49 | 38 | 35 | 44 | 45 | 45 | 48 |
| California | 0 | 53 | 72 | 217 | 275 | 377 | 457 | 502 | 569 | 574 | 633 | 669 | 707 | 746 | 803 | 859 | 960 | 1,026 | 1,096 | 1,165 |
| Connecticut | | | | 651 | 1,028 | 1,274 | 1,600 | 1,985 | 2,204 | 2,306 | 2,267 | 2,514 | 2,519 | 2,663 | 2,772 | 2,908 | 3,011 | 3,073 | 3,180 | 3,365 |
| Illinois | | | | | | | | | 16 | 82 | 167 | 323 | 403 | 454 | 481 | 531 | 556 | 592 | 601 | 656 |
| Indiana | | | | | | | | | | | 1,553 | 3589 | 4024 | 4,560 | 4,882 | 5,186 | 5,391 | 5,674 | 5,943 | 6,117 |
| Iowa | 274 | 1,131 | 1,550 | 1,957 | 2,338 | 2,630 | 2,937 | 3,338 | 3,637 | 4,092 | 4,436 | 4,890 | 5,121 | 5,496 | 5,869 | 6,231 | 6,520 | 6,941 | 7,310 | 7,695 |
| Kansas | | | | | | | | | | | 297 | 474 | 537 | 563 | 606 | 672 | 704 | 750 | 781 | 823 |
| Louisiana | | | | | | | | | | | | | | | | | 64 | 170 | 278 | 424 |
| Maine | 253 | 335 | 443 | 524 | 561 | 607 | 638 | 690 | 710 | 744 | 775 | 673 | 644 | 521 | 566 | 576 | 600 | 622 | 659 | 644 |
| Massachusetts | 3,731 | 4,039 | 4,241 | 4,464 | 4,778 | 5,112 | 5,227 | 5,391 | 5,781 | 6,227 | 6,515 | 6,957 | 6,928 | 6,968 | 6,760 | 7,213 | 6,947 | 7,080 | 7,309 | 7,520 |
| Michigan | | | | | | | | | | | | | | | | | 24 | 40 | 62 | 140 |
| Minnesota* | 4,237 | 5,001 | 5,429 | 5,837 | 6,166 | 6,495 | 6,444 | 6,314 | 6,098 | 6,101 | 6,072 | 6,092 | 6,483 | 6,510 | 6,463 | 6,487 | 6,221 | 6,209 | 5,986 | 6,165 |
| Mississippi | 10 | 22 | 37 | 64 | 85 | 130 | 169 | 234 | 275 | 315 | 356 | 372 | 405 | 431 | 459 | 481 | 512 | 834 | 1,331 | 1,343 |
| Missouri | | | | | | | | | | | 2,402 | 8,461 | 10954 | 12,954 | 13,946 | 15,155 | 16,508 | 17,619 | 18,153 | 18,610 |
| Nebraska | 30 | 55 | 88 | 90 | 96 | 92 | 95 | 88 | 87 | 87 | 90 | 114 | 114 | 114 | 111 | 111 | 111 | 101 | 70 | 67 |
| New Hampshire | | | | | | | | | 353 | 677 | 841 | 968 | 1,050 | 1,122 | 1,199 | 1,237 | 1,294 | 1,339 | 1,372 | 1,268 |
| New Jersey | | | | | N/S | N/S | N/S | N/S | 55 | 405 | 473 | 603 | 665 | 665 | 840 | 951 | 1,061 | 1,186 | 1,282 | 1,351 |
| New Mexico | | | | | 167 | 287 | 399 | 497 | 587 | 675 | 671 | 799 | 786 | 811 | 842 | 943 | 977 | 1,041 | 1,134 | 1,181 |
| New York | | | | | | | | | | | | | | | 500 | 702 | 1,146 | 1,526 | 2,002 | 2,480 |
| Nevada | | | | | | | | | | | | | | | | | | | | 7 |
| North Dakota | | | | | | | | | | | | | | | | | | 55 | 199 | 258 |
| Oregon | 209 | 252 | 263 | 335 | 396 | 434 | 444 | 464 | 502 | 521 | 546 | 591 | 739 | 690 | 624 | 585 | 564 | 565 | 571 | 583 |
| Pennsylvania | | | | | | | | | 299 | 869 | 1,356 | 1,250 | 1,599 | 1,599 | 2,120 | 2,466 | 2,852 | 3,263 | 3,700 | 4,865 |
| South Carolina | 43 | 53 | 56 | 68 | 83 | 84 | 88 | 84 | 82 | 67 | 69 | 77 | 70 | 46 | 53 | 53 | 51 | 47 | 49 | 52 |
| Utah | | | | | | | 96 | 161 | 183 | 230 | 170 | 180 | 190 | 190 | 165 | 198 | 228 | 243 | 239 | 260 |
| Vermont | 84 | 174 | 197 | 226 | 260 | 266 | 288 | 328 | 344 | 365 | 384 | 423 | 443 | 456 | 461 | 455 | 497 | 508 | 524 | 520 |

| | 2000 | | | | 2001 | | | | 2002 | | | | 2003 | | | | 2004 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| State | Mar | Jun | Sep | Dec | Mar | Jun | Sep | Dec | Mar | Jun | Sep | Dec | Mar | Jun | Sep | Dec | Mar | Jun | Sep | Dec |
| Washington | | | | | | | | | 20 | 58 | 106 | 144 | 170 | 195 | 207 | 237 | 312 | 334 | 389 | 448 |
| West Virginia | | | | | | | | | | | | | | | | | | 15 | 59 | 90 |
| Wisconsin | 80 | 284 | 605 | 942 | 1,234 | 1,386 | 1,568 | 1,714 | 2,310 | 2,869 | 3,313 | 3,837 | 4,282 | 4,655 | 5,047 | 5,269 | 6,096 | 6,511 | 7,186 | 7,713 |
| Wyoming | | | | | | | | | | | 1 | 1 | 1 | 1 | 6 | 4 | 2 | 2 | 4 | 5 |
| Total | 8,989 | 11,455 | 13,048 | 15,452 | 17,727 | 19,465 | 20,751 | 22,094 | 24,337 | 27,477 | 33,712 | 44,228 | 49,201 | 52,874 | 56,326 | 60,132 | 63,891 | 68,097 | 72,301 | 76,679 |

Source: State data submitted to CMS in quarterly progress reports.

N/S = not submitted. The program was operational but its enrollment data were not submitted.

**Table D.4: Comparison of Buy-In Program Enrollment Measures**

| State | Buy-In Enrollment, December 2003 (A) | Buy-In Enrollment per 100,000 State Residents Age 18 to 64, December 2003[a] (B) | Rank | Buy-In Enrollment as Percent of SSI Beneficiaries Who Work, December 2003[b] (C) | Rank | Buy-In Enrollment as Percent of Eligible SSDI Beneficiaries: SSDI Beneficiaries 2003 (D) | Highest monthly income level to receive other Medicaid ($) (E) | Percent of SSDI Beneficiaries with SSDI Benefits Over Highest Medicaid Level (F) | SSDI Beneficiaries Not Eligible for Medicaid Without Spending Down (G) | Buy-In Enrollment as a Percentage of Eligible SSDI Beneficiaries (H) | Rank |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Alaska | 192 | 46 | 12 | 33 | 11 | 8,719 | 1,025 | 32 | 2,764 | 6.9 | 8 |
| California | 859 | 4 | 22 | 2 | 22 | 500,805 | 978 | 35 | 175,282 | 0.5 | 20 |
| Connecticut | 2,908 | 134 | 8 | 76 | 5 | 60,506 | 747 | 54 | 32,492 | 8.9 | 5 |
| Illinois | 531 | 7 | 19 | 4 | 19 | 202,250 | 748 | 53 | 106,788 | 0.5 | 19 |
| Indiana | 5,186 | 135 | 7 | 91 | 4 | 127,447 | 552 | 74 | 93,928 | 5.5 | 10 |
| Iowa | 6,231 | 343 | 2 | 95 | 3 | 53,793 | 552 | 70 | 37,601 | 16.6 | 2 |
| Kansas | 672 | 40 | 13 | 17 | 13 | 47,741 | 552 | 72 | 34,135 | 2.0 | 13 |
| Maine[c] | 576 | 69 | 11 | 26 | 12 | 41,733 | 803 | 43 | 17,737 | 3.2 | 12 |
| Massachusetts | 7,213 | 176 | 4 | 75 | 6 | 138,588 | 995 | 30 | 41,576 | 17.3 | 1 |
| Minnesota | 6,487 | 202 | 3 | 70 | 7 | 80,252 | 748 | 73 | 58,183 | 11.1 | 4 |
| Missouri | 15,155 | 426 | 1 | 212 | 1 | 143,681 | 552 | 72 | 103,881 | 14.6 | 3 |
| Nebraska | 111 | 10 | 18 | 4 | 20 | 29,638 | 748 | 45 | 13,426 | 0.8 | 18 |
| New Hampshire | 1,237 | 149 | 6 | 99 | 2 | 28,510 | 566 | 77 | 21,981 | 5.6 | 9 |
| New Jersey | 951 | 18 | 16 | 13 | 16 | 140,617 | 748 | 57 | 80,011 | 1.2 | 16 |
| New Mexico | 943 | 82 | 10 | 44 | 9 | 38,332 | 552 | 72 | 27,522 | 3.4 | 11 |
| New York | 702 | 6 | 21 | 2 | 21 | 371,648 | 642 | 76 | 282,452 | 0.2 | 22 |
| Oregon | 585 | 26 | 15 | 15 | 15 | 67,580 | 554 | 73 | 49,333 | 1.2 | 17 |
| Pennsylvania | 2,466 | 32 | 14 | 16 | 14 | 259,516 | 748 | 52 | 134,170 | 1.8 | 14 |
| Utah | 198 | 14 | 17 | 9 | 17 | 25,583 | 748 | 48 | 12,178 | 1.6 | 15 |
| Vermont | 455 | 113 | 9 | 42 | 10 | 14,246 | 733 | 46 | 6,496 | 7.0 | 7 |
| Washington | 237 | 6 | 20 | 4 | 18 | 108,082 | 571 | 73 | 79,224 | 0.3 | 21 |
| Wisconsin | 5,269 | 154 | 5 | 52 | 8 | 98,234 | 636 | 73 | 71,220 | 7.4 | 6 |

Source: (A) Buy-In enrollment are from state data submitted to CMS in quarterly progress reports. (B) State-level population estimates are from the U.S. Census Bureau. (C) The number of SSI beneficiaries who work is from SSA (2005e). The concept and format for Buy-In enrollment as a percent of eligible SSDI beneficiaries was borrowed from Goodman and Livermore (2004). (D) SSA 2004, Table 9; (E) Based on information provided by state Buy-In personnel; (F) Computed based on state-level SSDI benefit distributions in SSA 2004, Table 16; (G, H) Computed.

Note: This table compares three measures of Buy-In program penetration that take into account different factors that vary across states: (1) Buy-In enrollment per 100,000 state residents age 18 to 64 accounts for states' varying population sizes; (2) Buy-In enrollment as a percent of SSI beneficiaries who work takes into account differences in the overall work environment for people with disabilities; and (3) Buy-In enrollment as a percent of SSDI beneficiaries who would be eligible for Medicaid eligibility groups other than the Buy-In without spending down takes into account differences in states' eligibility criteria for other means of obtaining Medicaid and also differences in the prevalence of disability. The third measure (Buy-In enrollment as a percent of eligible SSDI beneficiaries) above, used by Goodman and Livermore (2004), involves using the number of SSDI beneficiaries in a given state who would be ineligible for Medicaid without spending down as a proxy for the number of people eligible for the Buy-In program. SSDI beneficiaries comprise approximately 73 percent of new Buy-In enrollees (Figure V.3), suggesting that this may be a reasonable proxy.

[a]Calculation based on Buy-In enrollment in December 2003 and state population estimates from the Bureau of the Census Estimates for July 2003.
[b]Calculated as Buy-In enrollment in December 2003 divided by the total number of SSI beneficiaries who worked (including 1619(a) and 1619(b) participants) in 2003 (SSA 2005e).
[c]State personnel in Maine noted that problems with their eligibility system may have resulted in inaccurate enrollment numbers.

**Table D.5: Medicaid Status of Buy-In Participants Prior to Enrollment, by State, 2002-2004**

| | Total Participants (Number) | | | Enrolled in Medicaid (Percent) | | | Not Enrolled in Medicaid (Percent) | | | Medicaid Status Undetermined (Percent) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2002 | 2003 | 2004 | 2002 | 2003 | 2004 | 2002 | 2003 | 2004 | 2002 | 2003 | 2004 |
| Alaska | 131 | 129 | 134 | 100 | 67 | 63 | 0 | 33 | 37 | 0 | 0 | 0 |
| Arkansas | N/S[a] | N/S[a] | 17 | N/S[a] | N/S[a] | 41 | N/S[a] | N/S[a] | 59 | N/S[a] | N/S[a] | 0 |
| California | 403 | 471 | 681 | 98 | 90 | 91 | 2 | 10 | 9 | 0 | 0 | 0 |
| Connecticut | 1,534 | 1,285 | 1,265 | N/S | N/S | 92 | N/S | N/S | 8 | N/S | N/S | 0 |
| Illinois | 421 | 381 | 274 | 78 | 77 | 60 | 22 | 23 | 40 | 0 | 0 | 0 |
| Indiana | 4,297 | 3,702 | 3,129 | 95 | 88 | 79 | 5 | 12 | 21 | 0 | 0 | 0 |
| Iowa | 2,253 | 2,238 | 2,559 | 68 | 61 | 63 | 32 | 39 | 37 | 0 | 0 | 0 |
| Kansas | 516 | 355 | 331 | 81 | 70 | 69 | 19 | 30 | 31 | 0 | 0 | 0 |
| Louisiana | N/A | N/A | 522 | N/A | N/A | 42 | N/A | N/A | 58 | N/A | N/A | 0 |
| Maine | 451 | 435 | 353 | 61 | 83 | 86 | 39 | 17 | 14 | 0 | 0 | 0 |
| Massachusetts | 3,777 | 3,349 | 3,098 | 81 | 85 | 84 | 19 | 15 | 16 | 0 | 0 | 0 |
| Michigan | N/A | N/A | 125 | N/A | N/A | 100 | N/A | N/A | 0 | N/A | N/A | 0 |
| Minnesota | 1,706 | 1,862 | 1,376 | 64 | 69 | 73 | 36 | 31 | 27 | 0 | 0 | 0 |
| Missouri | 8,122 | 8,781 | 7,446 | 90 | 67 | 30 | 10 | 33 | 70 | 0 | 0 | 0 |
| Nebraska | 47 | 44 | 64 | 94 | 91 | 91 | 6 | 9 | 9 | 0 | 0 | 0 |
| New Hampshire | 1,084 | 510 | 616 | 74 | 58 | 72 | 26 | 42 | 28 | 0 | 0 | 0 |
| New Jersey | 419 | 543 | 678 | 7 | 56 | 55 | 93 | 44 | 45 | 0 | 0 | 0 |
| New Mexico | 630 | 731 | 876 | 56 | 62 | 64 | 44 | 38 | 36 | 0 | 0 | 0 |
| New York | N/A | 672 | 2,141 | N/A | 70 | 76 | N/A | 30 | 24 | N/A | 0 | 0 |
| North Dakota | N/A | N/A | 277 | N/A | N/A | 45 | N/A | N/A | 55 | N/A | N/A | 0 |
| Oregon | 291 | 338 | 160 | 77 | 88 | 82 | 23 | 12 | 18 | 0 | 0 | 0 |
| Pennsylvania | 1,476 | 1,815 | 1,026 | 21 | N/S | 100 | 79 | N/S | 0 | 0 | N/S | 0 |
| South Carolina | N/S[a] | N/S[a] | 19 | N/S[a] | N/S[a] | 79 | N/S[a] | N/S[a] | 21 | N/S[a] | N/S[a] | 0 |
| Utah | 265 | 229 | 263 | 69 | 81 | 86 | 31 | 19 | 14 | 0 | 0 | 0 |
| Vermont | 298 | 265 | 285 | 91 | 90 | 89 | 9 | 10 | 11 | 0 | 0 | 0 |
| Washington | 142 | 122 | 258 | 67 | 60 | 63 | 33 | 40 | 37 | 0 | 0 | 0 |
| West Virginia | N/A | N/A | 86 | N/A | N/A | 38 | N/A | N/A | 62 | N/A | N/A | 0 |

| | Total Participants (Number) | | | Enrolled in Medicaid (Percent) | | | Not Enrolled in Medicaid (Percent) | | | Medicaid Status Undetermined (Percent) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2002 | 2003 | 2004 | 2002 | 2003 | 2004 | 2002 | 2003 | 2004 | 2002 | 2003 | 2004 |
| Wisconsin | 2,722 | 2,759 | 3,228 | 74 | 71 | 75 | 26 | 29 | 25 | 0 | 0 | 0 |
| **Total** | **30,985** | **31,016** | **31,287** | **74** | **73** | **65** | **23** | **27** | **35** | **2** | **0** | **0** |

Source: State Annual Buy-In Report Forms for 2002 - 2004.

Note: The above enrollment data refers to individuals who enrolled in the Buy-In for the first time in a given year. Personnel in Pennsylvania noted that their 2004 data may be inaccurate. Information from a new data system that New York began using in 2005 suggests that the system from which the information above was drawn may have undercounted the number of New York Buy-In participants enrolled in Medicaid poverty-related category prior to Buy-In enrollment (see note to Table V.1 for a definition of the poverty-related category). This suggests that New York's proportion enrolled in Medicaid prior to Buy-In enrollment may be an underestimate of the true proportion.

[a]Arkansas and South Carolina had programs in 2002 and 2003 but did not have a Medicaid Infrastructure Grant and thus did not submit data.

N/A = not applicable because program did not begin until after the calendar year ended.
N/S = not submitted.

**Table D.6: SSDI Status at Buy-In Enrollment for Participants, by State, 2002-2004**

| | Total Participants | | | SSDI Status | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Percent with SSDI Benefits | | | Percent with No SSDI Benefits | | | Percent with Status Undetermined | | |
| State | 2002 | 2003 | 2004 | 2002 | 2003 | 2004 | 2002 | 2003 | 2004 | 2002 | 2003 | 2004 |
| Alaska | 131 | 129 | 134 | 72 | 67 | 56 | 28 | 33 | 44 | 0 | 0 | 0 |
| Arkansas | N/S[a] | N/S[a] | 17 | N/S[a] | N/S[a] | 29 | N/S[a] | N/S[a] | 71 | N/S[a] | N/S[a] | 0 |
| California | 403 | 471 | 681 | 10 | 77 | 85 | 90 | 23 | 15 | 0 | 0 | 0 |
| Connecticut | 1,534 | 1,285 | 1,265 | 82 | 80 | 80 | 18 | 20 | 20 | 0 | 0 | 0 |
| Illinois | 421 | 381 | 274 | 86 | 74 | 81 | 14 | 26 | 19 | 0 | 0 | 0 |
| Iowa | 2,253 | 2,238 | 2,559 | 85 | 83 | 85 | 15 | 17 | 15 | 0 | 0 | 0 |
| Kansas | 516 | 355 | 331 | 97 | 94 | 97 | 3 | 6 | 3 | 0 | 0 | 0 |
| Louisiana | N/A | N/A | 522 | N/A | N/A | 57 | N/A | N/A | 43 | N/A | N/A | 0 |
| Maine | 451 | 435 | 353 | 47 | 48 | 84 | 53 | 52 | 16 | 0 | 0 | 0 |
| Massachusetts | 3,777 | 3,349 | 3,098 | 44 | 57 | 57 | 56 | 43 | 43 | 0 | 0 | 0 |
| Michigan | N/A | N/A | 125 | N/A | N/A | 91 | N/A | N/A | 9 | N/A | N/A | 0 |
| Minnesota | 1,706 | 1,862 | 1,376 | 88 | 83 | 83 | 12 | 17 | 17 | 0 | 0 | 0 |
| Missouri | 8,122 | 8,781 | 7,446 | 87 | 77 | 71 | 13 | 23 | 29 | 0 | 0 | 0 |
| Nebraska | 47 | 44 | 64 | 98 | 100 | 100 | 2 | 0 | 0 | 0 | 0 | 0 |
| New Hampshire | 1,084 | 510 | 616 | 82 | 77 | 78 | 18 | 23 | 22 | 0 | 0 | 0 |
| New Jersey | 419 | 543 | 678 | N/S | N/S | 43 | N/S | N/S | 42 | N/S | N/S | 15 |
| New Mexico | 630 | 731 | 876 | 84 | 80 | 63 | 16 | 20 | 37 | 0 | 0 | 0 |
| New York | N/A | 672 | 2,141 | N/A | 79 | 80 | N/A | 21 | 20 | N/A | 0 | 0 |
| North Dakota | N/A | N/A | 277 | N/A | N/A | 77 | N/A | N/A | 23 | N/A | N/A | 0 |
| Oregon | 291 | 338 | 160 | 63 | 81 | 95 | 37 | 19 | 5 | 0 | 0 | 0 |
| Pennsylvania | 1,476 | 1,815 | 1,026 | 57 | 69 | 60 | 43 | 31 | 40 | 0 | 0 | 0 |
| South Carolina | N/S[a] | N/S[a] | 19 | N/S[a] | N/S[a] | 26 | N/S[a] | N/S[a] | 74 | N/S[a] | N/S[a] | 0 |
| Utah | 265 | 229 | 263 | 65 | 64 | 68 | 35 | 36 | 32 | 0 | 0 | 0 |
| Vermont | 298 | 265 | 285 | 54 | 80 | 93 | 46 | 20 | 7 | 0 | 0 | 0 |
| Washington | 142 | 122 | 258 | 97 | 81 | 86 | 3 | 19 | 14 | 0 | 0 | 0 |
| West Virginia | N/A | N/A | 86 | N/A | N/A | 9 | N/A | N/A | 91 | N/A | N/A | 0 |
| Wisconsin | 2,722 | 2,759 | 3,228 | 33 | 37 | 41 | 31 | 26 | 28 | 36 | 37 | 31 |
| Total | 26,688 | 27,314 | 28,158 | 70 | 71 | 69 | 26 | 25 | 27 | 4 | 4 | 4 |

Source: State Annual Buy-In Report Form for 2002 - 2004.

Note: The data refer to individuals enrolled in the Buy-In program for the first time in the given year. Indiana was excluded because it was unable to determine SSDI status for its first-time participants.

[a]Arkansas and South Carolina had a Buy-In program but not a Medicaid Infrastructure Grant and thus did not submit data.

N/A = not applicable because program did not exist until after calendar year ended.

N/S = not submitted.

**Table D.7: Health Insurance Status for Buy-In Participants During the Fourth Quarter of 2002 - 2004, by State**

| | Total Participants | | | Percent with Medicaid Only | | |
|---|---|---|---|---|---|---|
| State | 2002 | 2003 | 2004 | 2002 | 2003 | 2004 |
| Alaska | 186 | 179 | 173 | 42 | 12 | 1 |
| Arkansas | N/S[a] | N/S[a] | 45 | N/S[a] | N/S[a] | N/S |
| California | 651 | 807 | 1,085 | 15 | 11 | 10 |
| Connecticut | 2,075 | 2,505 | 2,940 | 12 | 2 | 14 |
| Illinois | 177 | 446 | 558 | 11 | 19 | 21 |
| Indiana | 2,344 | 5,006 | 5,899 | 54 | 22 | 27 |
| Iowa | 4,811 | 6,169 | 7,540 | 15 | 14 | 13 |
| Kansas | 384 | 621 | 782 | 8 | 9 | 8 |
| Louisiana | N/A | N/A | 385 | N/A | N/A | 43 |
| Maine | 617 | 733 | 591 | 18 | 52 | N/S |
| Massachusetts | 5,918 | 6,253 | 6,521 | 37 | 34 | 28 |
| Michigan | N/A | N/A | 84 | N/A | N/A | 6 |
| Minnesota | 5,932 | 6,178 | 5,731 | 7 | 8 | 7 |
| Missouri | 4,736 | 13,678 | 17,126 | N/S | 19 | 21 |
| Nebraska | 91 | 102 | 125 | 9 | 10 | 8 |
| New Hampshire | 880 | 1,110 | 1,027 | 16 | 18 | 15 |
| New Jersey | 516 | 892 | 1,276 | 17 | 13 | 45 |
| New Mexico | 712 | 890 | 1,155 | 68 | 65 | 61 |
| New York | N/A | 617 | 2,597 | N/A | 16 | 12 |
| North Dakota | N/A | N/A | 207 | N/A | N/A | N/S |
| Oregon | 531 | 565 | 543 | 12 | 5 | 10 |
| Pennsylvania | 888 | 2,196 | 3,721 | 14 | 11 | 10 |
| South Carolina | N/S[a] | N/S[a] | 50 | N/S[a] | N/S[a] | 30 |
| Utah | 138 | 118 | 168 | 22 | 22 | 10 |
| Vermont | 336 | 385 | 443 | 11 | 14 | 11 |
| Washington | 136 | 208 | 369 | 13 | 10 | 15 |
| West Virginia | N/A | N/A | 49 | N/A | N/A | 84 |
| Wisconsin | 3,339 | 5,165 | 7,092 | 16 | 15 | 12 |
| Total | 35,398 | 54,823 | 68,282 | 22 | 18 | 18 |

Source: State Annual Buy-In Report Forms for 2002 - 2004.

Note: The data above are for individuals enrolled for the entire fourth quarter of a given year. Personnel in Alaska (2002 and 2003), Connecticut (2002 and 2003), Indiana (2002 and 2003), Maine (2002 and 2003), New Jersey (2004), and Wisconsin (2002 and 2003) expressed concerns about the accuracy of their data.

[a]Arkansas and South Carolina had a Buy-In program but not a Medicaid Infrastructure Grant and thus did not submit data.

N/A = not applicable because the state's program did not begin until after calendar year ended.

N/S = not submitted.

**Table D.8: Percent of Participants with Other Health Insurance in Addition to Medicaid During the Fourth Quarter of 2002 - 2004, by State**

| State | Percent of Fourth-Quarter Participants with Coverage in Addition to Medicaid | | | Type of Coverage in Addition to Medicaid | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Medicare | | | Other Public Plan | | | Private Plan | | | Other | | |
| | 2002 | 2003 | 2004 | 2002 | 2003 | 2004 | 2002 | 2003 | 2004 | 2002 | 2003 | 2004 | 2002 | 2003 | 2004 |
| Alaska | 58 | 88 | 99 | 51 | 79 | 77 | 17 | 17 | 10 | 7 | 21 | 17 | 0 | 0 | 0 |
| Arkansas | N/S[a] | N/S[a] | N/S | N/S[a] | N/S[a] | N/S | N/S[a] | N/S[a] | N/S | N/S[a] | N/S[a] | N/S | N/S[a] | N/S[a] | N/S |
| California | 85 | 89 | 90 | 85 | 88 | 89 | 6 | 1 | 0 | 5 | 5 | 7 | 0 | 0 | 0 |
| Connecticut | 88 | 98 | 86 | 83 | 85 | 84 | 0 | 0 | 0 | 4 | 19 | 4 | 0 | 0 | 0 |
| Illinois | 89 | 81 | 79 | 86 | 77 | 78 | 0 | 0 | 0 | 16 | 19 | 11 | 0 | 0 | 0 |
| Indiana | 46 | 78 | 73 | 35 | 72 | 69 | 0 | 0 | 0 | 25 | 11 | 9 | 0 | 0 | 0 |
| Iowa | 85 | 86 | 87 | 83 | 85 | 86 | 0 | 0 | 0 | 2 | 2 | 1 | 0 | 0 | 0 |
| Kansas | 92 | 91 | 92 | 90 | 90 | 91 | 0 | 1 | 1 | 13 | 8 | 8 | 0 | 0 | 0 |
| Louisiana | N/A | N/A | 57 | N/A | N/A | 50 | N/A | N/A | 0 | N/A | N/A | 14 | N/A | N/A | 0 |
| Maine | 82 | 48 | 100 | 80 | 48 | 0 | 0 | 0 | 0 | 8 | 1 | 0 | 0 | 0 | 0 |
| Massachusetts | 63 | 66 | 72 | 55 | 58 | 65 | 0 | 0 | 0 | 8 | 8 | 6 | 0 | 0 | 0 |
| Michigan | N/A | N/A | 94 | N/A | N/A | 94 | N/A | N/A | 0 | N/A | N/A | 12 | N/A | N/A | 0 |
| Minnesota | 93 | 92 | 93 | 90 | 90 | 91 | 1 | 1 | 1 | 12 | 11 | 11 | 0 | 0 | 0 |
| Missouri | N/S | 81 | 79 | 80 | 76 | 76 | N/S | 4 | 2 | N/S | 2 | 1 | N/S | 0 | 0 |
| Nebraska | 91 | 90 | 92 | 91 | 90 | 92 | 0 | 0 | 0 | 3 | 2 | 6 | 4 | 2 | 2 |
| New Hampshire | 84 | 82 | 85 | 82 | 80 | 82 | 3 | 3 | 4 | 3 | 2 | 4 | 0 | 0 | 0 |
| New Jersey | 83 | 87 | 55 | 79 | 85 | 54 | 0 | 0 | 0 | 16 | 18 | 3 | 0 | 0 | 0 |
| New Mexico | 32 | 35 | 39 | 29 | 33 | 37 | 0 | 0 | 0 | 1 | 4 | 4 | 4 | 0 | 0 |
| New York | N/A | 84 | 88 | N/A | 79 | 76 | N/A | 0 | 0 | N/A | 5 | 12 | N/A | 0 | 0 |
| North Dakota | N/A | N/A | N/S | N/A | N/A | N/S | N/A | N/A | N/S | N/A | N/A | N/S | N/A | N/A | N/S |
| Oregon | 88 | 95 | 90 | 80 | 89 | 86 | 23 | 40 | 0 | 15 | 23 | 12 | 0 | 0 | 0 |
| Pennsylvania | 86 | 89 | 90 | 84 | 56 | 57 | 0 | 0 | 0 | 20 | 5 | 4 | 42 | 28 | 29 |
| South Carolina | N/S[a] | N/S[a] | 70 | N/S[a] | N/S[a] | 40 | N/S[a] | N/S[a] | 0 | N/S[a] | N/S[a] | 30 | N/S[a] | N/S[a] | 0 |
| Utah | 78 | 78 | 90 | 74 | 76 | 80 | 4 | 0 | 10 | 2 | 4 | 2 | 0 | 0 | 0 |
| Vermont | 89 | 86 | 89 | 88 | 85 | 89 | 0 | 0 | 0 | 7 | 5 | 4 | 0 | 0 | 0 |
| Washington | 88 | 90 | 85 | 86 | 89 | 80 | 0 | 0 | 0 | 1 | 3 | 4 | 1 | 0 | 1 |
| West Virginia | N/A | N/A | 16 | N/A | N/A | 10 | N/A | N/A | 0 | N/A | N/A | 6 | N/A | N/A | 0 |
| Wisconsin | 84 | 85 | 88 | 83 | 83 | 86 | 0 | 0 | 0 | 2 | 9 | 8 | 0 | 0 | 0 |
| Total | 78 | 82 | 82 | 75 | 76 | 76 | 1 | 2 | 1 | 8 | 7 | 5 | 1 | 1 | 2 |

Source: State Annual Buy-In Report Forms for 2002 -2004.

Note: The data above represent individuals enrolled for the entire fourth quarter of the given year. Type of coverage in addition to Medicaid calculated among participants with coverage in addition to Medicaid. Personnel in Alaska (2002 and 2003), Connecticut (2002 and 2003), Indiana (2002 and 2003), Maine (2002 and 2003), New Jersey (2004), and Wisconsin (2002 and 2003) expressed concerns about the accuracy of their data.

N/A = not applicable because program did not begin until calendar year ended.

N/S = not submitted.

[a]Arkansas and South Carolina had a Buy-In program but not a Medicaid Infrastructure Grant and thus did not submit data.

**Table D.9: Number and Percent of Participants with Reported UI Earnings in Fourth Quarter of 2004, By State**

| | Number of Fourth-Quarter Participants | Participants with Earnings | | Average Monthly Earnings ($) | Percent of Individuals with Earnings in Selected Categories | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Number | Percent | | $1-200 | $201-400 | $401-600 | $601-800 | $801-810 | $811-1000 | $1001-1200 | $1201-1400 | $1401-1600 | $1601-1800 | $1801-2000 | $2000+ |
| Alaska | 173 | 74 | 43 | 1,404 | 9 | 4 | 5 | 8 | 0 | 14 | 8 | 5 | 9 | 3 | 7 | 27 |
| Arkansas | 45 | 30 | 67 | 1,014 | 10 | 10 | 7 | 20 | 0 | 17 | 13 | 0 | 0 | 10 | 0 | 13 |
| California | 1,085 | 650 | 60 | 951 | 10 | 9 | 18 | 22 | 1 | 12 | 6 | 4 | 3 | 3 | 3 | 9 |
| Connecticut | 2,940 | 1,895 | 64 | 770 | 13 | 14 | 19 | 22 | 1 | 11 | 5 | 3 | 2 | 2 | 2 | 6 |
| Illinois | 558 | 415 | 74 | 732 | 10 | 13 | 22 | 26 | 2 | 9 | 5 | 4 | 3 | 2 | 0 | 3 |
| Indiana | 5,899 | 3,202 | 54 | 699 | 23 | 15 | 15 | 13 | 0 | 9 | 7 | 6 | 3 | 2 | 2 | 4 |
| Iowa | 7,540 | 2,016 | 27 | 500 | 28 | 19 | 19 | 18 | 1 | 7 | 3 | 2 | 1 | 1 | 1 | 1 |
| Kansas | 782 | 582 | 74 | 514 | 23 | 23 | 22 | 17 | 0 | 8 | 2 | 1 | 1 | 1 | 0 | 2 |
| Louisiana | 385 | 272 | 71 | 918 | 10 | 14 | 16 | 17 | 0 | 11 | 7 | 4 | 3 | 4 | 3 | 10 |
| Maine | 591 | 494 | 84 | 861 | 7 | 9 | 19 | 25 | 1 | 13 | 7 | 4 | 3 | 2 | 2 | 6 |
| Massachusetts | 6,521 | 3,988 | 61 | 1,211 | 6 | 9 | 16 | 18 | 1 | 10 | 5 | 4 | 5 | 4 | 5 | 17 |
| Minnesota | 5,731 | 3,317 | 58 | 640 | 20 | 17 | 20 | 21 | 1 | 9 | 4 | 2 | 1 | 1 | 1 | 3 |
| Missouri | 17,126 | 3,395 | 20 | 579 | 33 | 12 | 14 | 13 | 1 | 8 | 6 | 4 | 3 | 2 | 1 | 2 |
| Nebraska | 125 | 101 | 81 | 762 | 10 | 16 | 18 | 25 | 0 | 8 | 7 | 3 | 4 | 5 | 2 | 3 |
| New Hampshire | 1,027 | 584 | 57 | 720 | 24 | 18 | 16 | 13 | 1 | 7 | 4 | 3 | 2 | 2 | 3 | 7 |
| New Jersey | 1,276 | 870 | 68 | 897 | N/S | N/S | N/S | N/S | N/S | N/S | N/S | N/S | N/S | N/S | N/S | N/S |
| New Mexico | 1,155 | 329 | 28 | 1,369 | 7 | 9 | 16 | 12 | 2 | 9 | 8 | 6 | 7 | 3 | 4 | 18 |
| New York | 2,597 | 1,882 | 72 | 699 | 16 | 17 | 20 | 18 | 1 | 10 | 5 | 4 | 2 | 1 | 2 | 4 |
| North Dakota | 207 | 115 | 56 | 450 | 23 | 29 | 21 | 17 | 8 | 0 | 0 | 2 | 0 | 1 | 0 | 0 |
| Oregon | 543 | 407 | 75 | 895 | 6 | 15 | 20 | 22 | 1 | 11 | 5 | 3 | 4 | 3 | 2 | 9 |
| Pennsylvania | 3,721 | 2,234 | 60 | 865 | 11 | 14 | 17 | 17 | 1 | 11 | 8 | 6 | 5 | 3 | 3 | 6 |
| South Carolina | 50 | 38 | 76 | 1,531 | 8 | 5 | 8 | 8 | 0 | 8 | 8 | 8 | 0 | 5 | 8 | 34 |
| Utah | 168 | 94 | 56 | 567 | 18 | 12 | 34 | 18 | 2 | 5 | 5 | 3 | 1 | 0 | 0 | 1 |
| Vermont | 443 | 313 | 71 | 716 | 11 | 17 | 18 | 20 | 2 | 13 | 6 | 4 | 3 | 1 | 1 | 3 |
| Washington | 369 | 289 | 78 | 724 | 13 | 15 | 21 | 22 | 1 | 9 | 6 | 2 | 3 | 2 | 2 | 4 |
| West Virginia | 49 | 28 | 57 | 1,179 | 0 | 14 | 0 | 11 | 0 | 7 | 18 | 14 | 14 | 11 | 4 | 7 |
| Wisconsin | 7,092 | 1,884 | 27 | 522 | 26 | 21 | 19 | 18 | 0 | 6 | 2 | 2 | 1 | 1 | 1 | 2 |
| Total | 68,198 | 29,498 | 43 | 766 | 18 | 15 | 17 | 18 | 1 | 9 | 5 | 4 | 3 | 2 | 2 | 6 |

Source: State Annual Buy-In Report Forms for 2004.

Note: The data above are shown for those participants who were enrolled for the entire fourth quarter of 2004. Percentages for a given state may not sum to 100 due to rounding. Michigan did not submit earnings data, and New Jersey did not provide information on the percent of individuals in earnings categories.

N/S = not submitted

**Table D.10: Number and Percent of Participants with Reported UI Earnings in Fourth Quarter of 2003, by State**

| | Number of Fourth-Quarter Participants | Participants with Earnings | | Average Monthly Earnings ($) | Total Quarterly Earnings ($) | Percent of Individuals with Earnings in Selected Categories | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Number | Percent | | | $1-200 | $201-400 | $401-600 | $601-800 | $801-1000 | $1001-1200 | $1201-1400 | $1401-1600 | $1601+ |
| Alaska | 179 | 73 | 41 | 1,337 | 292,848 | 5 | 8 | 10 | 11 | 10 | 7 | 5 | 7 | 37 |
| California | 807 | 470 | 58 | 984 | 1,387,762 | 10 | 11 | 20 | 20 | 10 | 5 | 4 | 4 | 15 |
| Connecticut | 2,505 | 1,516 | 61 | 749 | 3,408,351 | 10 | 20 | 22 | 22 | 11 | 5 | 3 | 0 | 8 |
| Illinois | 446 | 309 | 69 | 612 | 567,594 | 13 | 18 | 25 | 24 | 9 | 3 | 2 | 2 | 4 |
| Iowa | 6,169 | 1,524 | 25 | 446 | 2,039,156 | 32 | 22 | 19 | 15 | 5 | 2 | 1 | 1 | 2 |
| Kansas | 621 | 484 | 78 | 509 | 739,097 | 19 | 26 | 24 | 15 | 7 | 3 | 1 | 1 | 3 |
| Maine | 733 | 554 | 76 | 1,003 | 1,667,181 | 5 | 10 | 14 | 22 | 15 | 6 | 5 | 5 | 18 |
| Massachusetts | 6,253 | 3,310 | 53 | 1,209 | 12,008,827 | 6 | 9 | 16 | 18 | 8 | 5 | 6 | 5 | 27 |
| Minnesota | 6,178 | 3,377 | 55 | 628 | 6,363,031 | 22 | 19 | 19 | 21 | 7 | 3 | 2 | 2 | 5 |
| Missouri | 13,678 | 2,626 | 19 | 573 | 4,513,091 | 26 | 17 | 18 | 14 | 8 | 5 | 4 | 3 | 4 |
| Nebraska | 102 | 79 | 77 | 895 | 121,022 | 6 | 6 | 25 | 28 | 8 | 5 | 3 | 1 | 18 |
| New Hampshire | 1,110 | 731 | 66 | 579 | 1,269,351 | 20 | 22 | 19 | 18 | 9 | 3 | 2 | 2 | 4 |
| New Mexico | 890 | 345 | 39 | 943 | 976,069 | 4 | 4 | 3 | 3 | 4 | 4 | 4 | 8 | 67 |
| New York | 617 | 453 | 73 | 563 | 765,136 | 16 | 18 | 22 | 20 | 7 | 5 | 3 | 2 | 8 |
| Oregon | 565 | 406 | 72 | 829 | 1,010,291 | 9 | 17 | 22 | 21 | 8 | 4 | 3 | 3 | 12 |
| Utah | 118 | 61 | 52 | 564 | 103,176 | 11 | 20 | 26 | 33 | 7 | 0 | 0 | 0 | 3 |
| Vermont | 385 | 279 | 72 | 698 | 584,447 | 10 | 16 | 24 | 23 | 9 | 5 | 4 | 1 | 7 |
| Washington | 208 | 163 | 78 | 729 | 356,270 | 15 | 15 | 18 | 25 | 9 | 5 | 3 | 2 | 9 |
| Wisconsin | 5,165 | 1,904 | 37 | 552 | 3,152,647 | 26 | 20 | 19 | 17 | 7 | 3 | 2 | 2 | 5 |
| Total | 46,729 | 18,664 | 39 | 739 | 41,325,347 | 18 | 17 | 19 | 18 | 8 | 4 | 3 | 3 | 11 |

Source: State Annual Buy-In Report Forms for 2003.

Note: The data above are shown for those participants who were enrolled for the entire fourth quarter of 2003. Percentages for a given state may not sum to 100 due to rounding. Data for Indiana and Pennsylvania are not included because they did not use the UI system, thus rendering their data non-comparable with other states. New Jersey did not submit these data. Programs in the following states did not begin until 2004: Louisiana, Michigan, North Dakota, and West Virginia. Two states (Arkansas and South Carolina) had programs in 2003 but did not have a Medicaid Infrastructure Grant and thus did not submit data.

**Table D.11: Number and Percent of Participants with Reported UI Earnings in Fourth Quarter of 2002, by State**

| | Number of Fourth-Quarter Participants | Participants with Earnings | | Average Monthly Earnings ($) | Total Quarterly Earnings ($) | Percent of Individuals with Earnings in Selected Categories | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Number | Percent | | | $1-200 | $201-400 | $401-600 | $601-800 | $801-1000 | $1001-1200 | $1201-1400 | $1401-1600 | $1601+ |
| Alaska | 186 | 67 | 36 | 942 | 189,343 | 12 | 10 | 13 | 16 | 13 | 9 | 7 | 1 | 16 |
| Connecticut | 2,075 | 1,542 | 74 | 665 | 3,077,796 | 19 | 17 | 23 | 20 | 6 | 4 | 3 | 1 | 7 |
| Illinois | 177 | 127 | 72 | 607 | 231,138 | 12 | 13 | 33 | 26 | 5 | 2 | 2 | 6 | 2 |
| Iowa | 4,811 | 1,570 | 33 | 471 | 2,217,844 | 28 | 21 | 20 | 18 | 5 | 2 | 2 | 1 | 2 |
| Kansas | 384 | 282 | 73 | 415 | 350,797 | 23 | 31 | 24 | 15 | 4 | 1 | 0 | 0 | 1 |
| Maine | 617 | 359 | 58 | 806 | 868,056 | 13 | 16 | 18 | 16 | 7 | 9 | 7 | 4 | 11 |
| Massachusetts | 5,918 | 3,201 | 54 | 1,188 | 11,404,125 | 6 | 9 | 17 | 17 | 7 | 5 | 6 | 6 | 25 |
| Minnesota | 5,932 | 3,196 | 54 | 590 | 5,661,454 | 24 | 18 | 22 | 19 | 6 | 2 | 2 | 1 | 5 |
| Missouri | 4,736 | 1,229 | 26 | 513 | 1,891,268 | 26 | 20 | 22 | 15 | 6 | 4 | 2 | 2 | 3 |
| Nebraska | 91 | 75 | 82 | 851 | 191,551 | 3 | 4 | 31 | 29 | 9 | 5 | 3 | 4 | 12 |
| New Hampshire | 880 | 628 | 71 | 530 | 998,677 | 24 | 21 | 22 | 16 | 5 | 3 | 3 | 1 | 4 |
| New Mexico | 712 | 178 | 25 | 917 | 489,652 | 10 | 10 | 15 | 20 | 16 | 7 | 5 | 4 | 13 |
| Oregon | 531 | 381 | 72 | 895 | 1,022,879 | 14 | 15 | 19 | 18 | 7 | 6 | 2 | 3 | 16 |
| Utah | 138 | 63 | 46 | 422 | 79,783 | 32 | 21 | 30 | 8 | 3 | 0 | 0 | 3 | 3 |
| Vermont | 336 | 246 | 73 | 645 | 476,027 | 14 | 20 | 20 | 26 | 6 | 4 | 2 | 3 | 6 |
| Washington | 136 | 109 | 80 | 554 | 181,084 | 19 | 21 | 17 | 26 | 10 | 2 | 3 | 0 | 3 |
| Wisconsin | 3,339 | 1,480 | 44 | 532 | 2,364,062 | 26 | 19 | 22 | 18 | 6 | 2 | 2 | 1 | 4 |
| Total | 30,999 | 14,733 | 47 | 716 | 31,695,536 | 19 | 17 | 20 | 18 | 6 | 4 | 3 | 3 | 9 |

Source: State Annual Buy-In Report Forms for 2002.

Note: The data above are shown for those participants who were enrolled for the entire fourth quarter of 2002. Percentages for a given state may not sum to 100 due to rounding. New Jersey did not submit earnings data. Data for three states are not included because they either did not use the UI system (Indiana and Pennsylvania) or used a data source in addition to the UI system (California), thus rendering their data non-comparable with other states. New York's program did not begin until 2003, and programs in the following states did not begin until 2004: Louisiana, Michigan, North Dakota, and West Virginia. Two states (Arkansas and South Carolina) had programs in 2003 but did not have a Medicaid Infrastructure Grant and thus did not submit data.

**Table D.12: Participants with 2004 Fourth Quarter Self-Employment Earnings and Amount of Earnings, by State**

| | Average Monthly Earnings ($) | Total Quarterly Earnings ($) | Total Fourth-Quarter Participants | Total with Self-Employment Earnings | Percent with Self-Employment Earnings | Number of Participants in Monthly Self-Employment Earnings Categories | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | $1-200 | $201-400 | $401-600 | $601-800 | $801-810 | $811-1000 | $1001-1200 | $1201-1400 | $1401-1600 | $1601-1800 | $1801-2000 | $2001+ |
| California | 234 | 75,141 | 1,085 | 107 | 10 | 73 | 15 | 8 | 5 | 0 | 2 | 2 | 0 | 0 | 1 | 0 | 1 |
| Connecticut | 414 | 52,118 | 2,940 | 42 | 1 | 17 | 13 | 7 | 2 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 2 |
| Indiana | 421 | 439,235 | 5,899 | 348 | 6 | 176 | 65 | 31 | 15 | 0 | 21 | 11 | 9 | 5 | 3 | 2 | 10 |
| Kansas | 262 | 34,570 | 782 | 44 | 6 | 21 | 12 | 7 | 2 | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 |
| Louisiana | 586 | 21,081 | 385 | 12 | 3 | 4 | 2 | 2 | 2 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 1 |
| Minnesota | 223 | 353,623 | 5,731 | 529 | 9 | 378 | 80 | 28 | 16 | 3 | 10 | 3 | 2 | 3 | 1 | 1 | 4 |
| Nebraska | N/S | N/S | 125 | 4 | 3 | N/S | N/S | N/S | N/S | N/S | N/S | N/S | N/S | N/S | N/S | N/S | N/S |
| New Hampshire | 294 | 60,908 | 1,027 | 69 | 7 | 42 | 13 | 3 | 6 | 0 | 2 | 1 | 0 | 0 | 1 | 0 | 1 |
| New Mexico | 1002 | 126,232 | 1,155 | 42 | 4 | 1 | 16 | 7 | 7 | 0 | 0 | 2 | 1 | 1 | 2 | 0 | 5 |
| North Dakota | 151 | 4,990 | 207 | 11 | 5 | 9 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| South Carolina | 289 | 867 | 50 | 1 | 2 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 |
| Utah | 302 | 25,376 | 168 | 28 | 17 | 19 | 5 | 1 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 0 |
| Vermont | 680 | 114,235 | 443 | 56 | 13 | 25 | 6 | 6 | 2 | 0 | 3 | 4 | 0 | 2 | 3 | 0 | 5 |
| Washington | 429 | 38,636 | 369 | 30 | 8 | 11 | 5 | 8 | 3 | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 1 |
| West Virginia | 937 | 5,623 | 49 | 2 | 4 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 |

Source: State Annual Buy-In Report Forms for 2004.

Note: The data above represent individuals enrolled for the entire fourth quarter of 2004. The following states did not submit self-employment earnings data: Alaska, Arkansas, Illinois, Iowa, Maine, Massachusetts, Michigan, Missouri, New Jersey, New York, Oregon, Pennsylvania, and Wisconsin.

N/S = not submitted.

**Table D.13: Participants with 2003 Fourth Quarter Self-Employment Earnings and Amount of Earnings, by State**

| | Average Monthly Earnings ($) | Total Quarterly Earnings ($) | Total Fourth-Quarter Participants | Total with Self-Employment Earnings | Percent with Self-Employment Earnings | Number of Participants in Monthly Self-Employment Earnings Categories | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | $1-200 | $201-400 | $401-600 | $601-800 | $801-1000 | $1001-1200 | $1201-1400 | $1401-1600 | $1601+ |
| California | 400 | 87,640 | 807 | 73 | 9 | 37 | 16 | 4 | 2 | 7 | 1 | 2 | 0 | 4 |
| Connecticut | 370 | 37,765 | 2,505 | 34 | 1 | 16 | 9 | 6 | 0 | 2 | 0 | 0 | 0 | 1 |
| Indiana | 413 | 287,614 | 5,006 | 232 | 5 | 109 | 46 | 24 | 7 | 18 | 13 | 2 | 5 | 8 |
| Kansas | 430 | 25,770 | 621 | 20 | 3 | 6 | 6 | 3 | 3 | 1 | 0 | 0 | 0 | 1 |
| Minnesota | 188 | 343,466 | 6,178 | 610 | 10 | 458 | 80 | 38 | 11 | 6 | 4 | 1 | 1 | 11 |
| Nebraska | N/S | N/S | 102 | 5 | 5 | N/S | N/S | N/S | N/S | N/S | N/S | N/S | N/S | N/S |
| New Hampshire | 258 | 40,300 | 1,110 | 52 | 5 | 25 | 13 | 9 | 3 | 2 | 0 | 0 | 0 | 0 |
| New Mexico | 434 | 35,139 | 890 | 27 | 3 | 0 | 7 | 6 | 0 | 2 | 3 | 0 | 0 | 9 |
| Utah | 230 | 20,704 | 118 | 30 | 25 | 13 | 4 | 2 | 3 | 4 | 0 | 0 | 0 | 4 |
| Vermont | 588 | 79,321 | 385 | 45 | 12 | 14 | 12 | 5 | 3 | 4 | 2 | 1 | 0 | 4 |
| Washington | 193 | 1,157 | 208 | 2 | 1 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Wisconsin | N/S | N/S | 5,165 | 1,072 | 21 | N/S | N/S | N/S | N/S | N/S | N/S | N/S | N/S | N/S |

Source: State Annual Buy-In Report Forms for 2004.

Note: The data above represent individuals enrolled for the entire fourth quarter of 2003. The following states did not submit self-employment earnings data: Alaska, Illinois, Iowa, Maine, Massachusetts, Missouri, New Jersey, Oregon, and Pennsylvania. New York's program did not begin until 2003, and programs in the following states did not begin until 2004: Louisiana, Michigan, North Dakota, and West Virginia. Two states (Arkansas and South Carolina) had programs in 2003 but did not have a Medicaid Infrastructure Grant and thus did not submit data.

N/S = not submitted.

**Table D.14: Participants with 2002 Fourth Quarter Self-Employment Earnings and Amount of Earnings, by State**

| | Average Monthly Earnings ($) | Total Quarterly Earnings ($) | Total Fourth-Quarter Participants | Total with Self-Employment Earnings | Percent with Self-Employment Earnings | Number of Participants in Monthly Self-Employment Earnings Categories | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | $1-200 | $201-400 | $401-600 | $601-800 | $801-1000 | $1001-1200 | $1201-1400 | $1401-1600 | $1601+ |
| California | 131 | 32,682 | 651 | 83 | 13 | 45 | 12 | 7 | 5 | 5 | 1 | 3 | 1 | 4 |
| Connecticut | 770 | 62,400 | 2,075 | 27 | 1 | 5 | 7 | 4 | 4 | 1 | 1 | 0 | 1 | 4 |
| Kansas | 409 | 17,166 | 384 | 14 | 4 | 1 | 0 | 2 | 1 | 1 | 3 | 1 | 1 | 4 |
| Minnesota | 166 | 272,684 | 5,932 | 549 | 9 | 430 | 67 | 21 | 15 | 8 | 1 | 0 | 2 | 5 |
| New Hampshire | 361 | 28,150 | 880 | 26 | 3 | 11 | 4 | 5 | 4 | 0 | 1 | 1 | 0 | 0 |
| New Mexico | 426 | 20,438 | 712 | 16 | 2 | 1 | 3 | 3 | 1 | 0 | 0 | 0 | 2 | 6 |
| Utah | 265 | 23,073 | 138 | 29 | 21 | 12 | 7 | 1 | 0 | 4 | 0 | 0 | 1 | 4 |
| Vermont | 799 | 91,111 | 336 | 38 | 11 | 12 | 3 | 9 | 5 | 3 | 1 | 1 | 1 | 3 |

Source: State Annual Buy-In Report Forms for 2002.

Note: The data above represent individuals enrolled for the entire fourth quarter of 2002. The following states did not submit self-employment earnings data: Alaska, Illinois, Indiana, Iowa, Maine, Massachusetts, Missouri, Nebraska, New Jersey, Oregon, Pennsylvania, Washington, and Wisconsin. New York's program did not begin until 2003, and programs in the following states did not begin until 2004: Louisiana, Michigan, North Dakota, and West Virginia. Two states (Arkansas and South Carolina) had programs in 2003 but did not have a Medicaid Infrastructure Grant and thus did not submit data.

**Table D.15: Change in Total Quarterly UI Earnings, Average Monthly Earnings, and Percent with UI Earnings from 2003 to 2004, by State**

| State | Total Participants | Total Quarterly Earnings | | % Change | Average Monthly Earnings[a] | | % Change | Percent with Earnings | |
|---|---|---|---|---|---|---|---|---|---|
| | | 2003 | 2004 | | 2003 | 2004 | | 2003 | 2004 |
| Alaska | 90 | 138,176 | 139,934 | 1 | 1,279 | 1,372 | 7 | 40 | 38 |
| Arkansas | 28 | 53,775 | 58,895 | 10 | 896 | 982 | 10 | 71 | 71 |
| Connecticut | 1,783 | 2,805,357 | 2,609,687 | -7 | 713 | 745 | 4 | 74 | 66 |
| Illinois | 300 | 434,296 | 465,023 | 7 | 611 | 689 | 13 | 79 | 75 |
| Iowa | 5,164 | 1,509,032 | 2,311,893 | 53 | 433 | 506 | 17 | 23 | 30 |
| Kansas | 481 | 592,000 | 553,831 | -6 | 513 | 510 | -1 | 80 | 75 |
| Maine | 294 | 674,251 | 642,504 | -5 | 888 | 881 | -1 | 86 | 83 |
| Massachusetts | 3,891 | 9,878,124 | 9,284,148 | -6 | 1,210 | 1,267 | 5 | 70 | 63 |
| Minnesota | 4,442 | 4,876,603 | 4,731,150 | -3 | 634 | 637 | 0 | 58 | 56 |
| Missouri | 10,429 | 2,357,470 | 2,754,488 | 17 | 440 | 530 | 20 | 17 | 17 |
| Nebraska | 71 | 161,765 | 119,801 | -26 | 843 | 753 | -11 | 90 | 75 |
| New Hampshire | 665 | 863,197 | 810,793 | -6 | 606 | 702 | 16 | 71 | 58 |
| New Jersey | 726 | 1,271,775 | 1,375,431 | 8 | 811 | 901 | 11 | 72 | 70 |
| New Mexico | 440 | 138,301 | 126,233 | -9 | 981 | 258 | -74 | 11 | 37 |
| New York | 551 | 811,295 | 742,396 | -8 | 663 | 676 | 2 | 74 | 66 |
| Oregon | 396 | 815,136 | 805,100 | -1 | 891 | 925 | 4 | 77 | 73 |
| South Carolina | 38 | 150,971 | 141,488 | -6 | 1,480 | 1,626 | 10 | 89 | 76 |
| Utah | 65 | 60,051 | 62,675 | 4 | 556 | 580 | 4 | 55 | 55 |
| Vermont | 225 | 313,943 | 308,666 | -2 | 658 | 681 | 4 | 71 | 67 |
| Washington | 145 | 267,194 | 251,378 | -6 | 748 | 722 | -3 | 82 | 80 |
| Wisconsin | 4,248 | 2,443,485 | 2,523,049 | 3 | 532 | 577 | 9 | 36 | 34 |
| Total | 40,178 | 30,616,197 | 30,818,563 | 1 | 751 | 777 | 4 | 41 | 40 |

Source: State Annual Buy-In Report Forms for 2004.

Note: The data above are for individuals enrolled in the Buy-In for the entire fourth quarter of 2004 and for the entire fourth quarter of 2003. California, Indiana, and Pennsylvania did not submit these data. Four states (Louisiana, Michigan, North Dakota, and West Virginia) did not submit these data because their programs did not begin until 2004.

[a]Calculated among participants with UI earnings.

**Table D.16: Change in Total Quarterly UI Earnings, Average Monthly Earnings, and Percent with Earnings from 2002 To 2003, by State**

| State | Total Participants | Total Quarterly Earnings | | | Average Monthly Earnings[a] | | | Percent with Earnings | |
|---|---|---|---|---|---|---|---|---|---|
| | | 2002 | 2003 | % Change | 2002 | 2003 | % Change | 2002 | 2003 |
| Alaska | 66 | 73,984 | 82,782 | 12 | 1,233 | 1,452 | 18 | 30 | 29 |
| California | 453 | 691,235 | 718,357 | 4 | 847 | 943 | 11 | 60 | 56 |
| Connecticut | 1,450 | 2,267,176 | 2,023,209 | -11 | 716 | 757 | 6 | 73 | 61 |
| Illinois | 114 | 146,704 | 120,299 | -18 | 582 | 535 | -8 | 74 | 66 |
| Iowa | 4,057 | 1,831,924 | 1,405,822 | -23 | 464 | 440 | -5 | 32 | 26 |
| Kansas | 305 | 315,293 | 329,057 | 4 | 419 | 471 | 12 | 82 | 76 |
| Maine | 449 | 1,025,815 | 1,073,757 | 5 | 991 | 1,098 | 11 | 77 | 73 |
| Massachusetts | 3,316 | 7,725,635 | 7,018,564 | -9 | 1,222 | 1,274 | 4 | 64 | 55 |
| Minnesota | 4,503 | 4,419,876 | 4,492,021 | 2 | 591 | 630 | 6 | 55 | 53 |
| Missouri | 3,925 | 1,235,843 | 1,174,120 | -5 | 469 | 480 | 2 | 22 | 21 |
| Nebraska | 60 | 144,902 | 128,692 | -11 | 805 | 715 | -11 | 87 | 77 |
| New Hampshire | 654 | 750,349 | 688,869 | -8 | 516 | 532 | 3 | 74 | 66 |
| New Mexico | 322 | 141,954 | 138,301 | -3 | 986 | 1,024 | 4 | 15 | 14 |
| Oregon | 320 | 764,148 | 762,586 | 0 | 1,103 | 1,110 | 1 | 72 | 72 |
| Utah | 55 | 40,755 | 35,979 | -12 | 453 | 444 | -2 | 55 | 49 |
| Vermont | 197 | 258,858 | 274,901 | 6 | 591 | 632 | 7 | 74 | 74 |
| Washington | 99 | 147,332 | 157,280 | 7 | 599 | 699 | 17 | 83 | 76 |
| Wisconsin | 2,751 | 1,921,631 | 1,873,779 | -2 | 526 | 545 | 4 | 44 | 42 |
| Total | 23,096 | 23,903,414 | 22,498,375 | -6 | 721 | 751 | 4 | 48 | 44 |

Source: State Annual Buy-In Report Forms for 2003.

Note: The data above are for individuals enrolled in the Buy-In for the entire fourth quarter of 2003 and for the entire fourth quarter of 2002. Data for Indiana and Pennsylvania are not included because they did not use the UI system, thus rendering their data non-comparable with other states. New Jersey did not submit these data. New York's program did not begin until 2003, and programs in the following states did not begin until 2004: Louisiana, Michigan, North Dakota, and West Virginia. Two states (Arkansas and South Carolina) had programs in 2003 but did not have a Medicaid Infrastructure Grant and thus did not submit data.

[a]Calculated among participants with UI earnings.

**Table D.17: Change in Total Quarterly UI Earnings, Average Monthly Earnings, and Percent with UI Earnings from 2001 to 2002, by State**

| State | Total Participants | Total Quarterly Earnings | | Average Monthly Earnings[a] | | Percent with Earnings | |
|---|---|---|---|---|---|---|---|
| | | 2001 | 2002 | 2001 | 2002 | 2001 | 2002 |
| Alaska | 79 | 87,966 | 74,228 | 977 | 884 | 38 | 35 |
| Connecticut | 905 | 1,427,457 | 1,297,720 | 615 | 647 | 86 | 74 |
| Iowa | 2,729 | 1,469,660 | 1,438,213 | 453 | 473 | 40 | 37 |
| Maine | 320 | 472,313 | 441,632 | 772 | 796 | 64 | 58 |
| Massachusetts | 3,237 | 8,189,967 | 7,094,788 | 1,295 | 1,259 | 65 | 58 |
| Minnesota | 4,389 | 4,236,221 | 4,197,400 | 579 | 600 | 56 | 53 |
| Nebraska | 51 | 119,964 | 111,454 | 784 | 729 | 90 | 86 |
| New Mexico | 217 | 120,970 | 141,954 | 840 | 986 | 22 | 22 |
| Oregon | 299 | 747,970 | 693,448 | 1,160 | 1,085 | 72 | 71 |
| Utah | 31 | 20,334 | 21,791 | 295 | 346 | 74 | 68 |
| Vermont | 141 | 176,392 | 178,756 | 582 | 567 | 72 | 74 |
| Wisconsin | 1,194 | 1,135,705 | 1,065,541 | 549 | 558 | 58 | 53 |
| Total | 13,592 | 18,204,919 | 16,756,925 | 787 | 784 | 57 | 53 |

Source: State Annual Buy-In Report Forms for 2002.

Note: The data above are for individuals enrolled in the Buy-In for the entire fourth quarter of 2002 and for the entire fourth quarter of 2001. The following states were unable to provide these data for the 2002 Annual Report because they did not have Buy-In programs for the entire 2001 calendar year: Illinois, Indiana, Kansas, Missouri, New Hampshire, New York, and Pennsylvania. Data for California were excluded because these states used sources in addition to the UI system to provide these data. New Jersey did not submit these data. New York's program did not begin until 2003, and programs in the following states did not begin until 2004: Louisiana, Michigan, North Dakota, and West Virginia. Two states (Arkansas and South Carolina) had programs in 2003 but did not have a Medicaid Infrastructure Grant and thus did not submit data.

[a]Calculated among participants with UI earnings.

**Table D.18: Mean Monthly UI Earnings in 2003 and 2004, by State**

| State | Total Participants with Earnings | | Percent of Participants with Monthly Earnings in Selected Categories[a] | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | $1-200 | | $201-400 | | $401-600 | | $601-800 | | $801-810 | | $811-1000 | | $1001-1200 | | $1201-1400 | | $1401-1600 | | $1601+ | |
| | 2003 | 2004 | 2003 | 2004 | 2003 | 2004 | 2003 | 2004 | 2003 | 2004 | 2003 | 2004 | 2003 | 2004 | 2003 | 2004 | 2003 | 2004 | 2003 | 2004 | 2003 | 2004 |
| Alaska | 36 | 34 | 6 | 6 | 6 | 0 | 17 | 9 | 8 | 18 | 0 | 0 | 11 | 15 | 8 | 6 | 3 | 3 | 8 | 9 | 33 | 35 |
| Arkansas | 20 | 20 | 15 | 15 | 15 | 5 | 10 | 10 | 10 | 10 | 0 | 0 | 10 | 20 | 10 | 20 | 5 | 0 | 10 | 0 | 15 | 20 |
| Connecticut | 1,312 | 1,168 | 12 | 13 | 17 | 13 | 22 | 21 | 23 | 24 | 1 | 1 | 9 | 10 | 4 | 4 | 3 | 3 | 1 | 2 | 7 | 8 |
| Illinois | 237 | 225 | 12 | 12 | 18 | 14 | 32 | 22 | 21 | 26 | 0 | 1 | 7 | 10 | 4 | 5 | 2 | 3 | 1 | 3 | 3 | 5 |
| Iowa | 1,162 | 1,524 | 32 | 27 | 22 | 19 | 20 | 19 | 16 | 19 | 0 | 1 | 5 | 6 | 2 | 3 | 1 | 2 | 1 | 1 | 2 | 3 |
| Kansas | 385 | 362 | 18 | 25 | 26 | 21 | 24 | 23 | 16 | 16 | 1 | 0 | 6 | 7 | 3 | 2 | 1 | 1 | 1 | 1 | 3 | 3 |
| Maine | 253 | 243 | 4 | 6 | 8 | 7 | 17 | 18 | 28 | 28 | 2 | 1 | 18 | 16 | 6 | 7 | 3 | 5 | 3 | 2 | 11 | 12 |
| Massachusetts | 2,721 | 2,442 | 4 | 5 | 9 | 8 | 17 | 15 | 20 | 20 | 1 | 1 | 8 | 10 | 5 | 5 | 5 | 4 | 5 | 4 | 26 | 27 |
| Minnesota | 2,562 | 2,477 | 20 | 21 | 20 | 17 | 21 | 20 | 22 | 21 | 1 | 1 | 7 | 9 | 2 | 3 | 1 | 2 | 1 | 1 | 4 | 5 |
| Missouri | 1,787 | 1,733 | 41 | 36 | 15 | 13 | 16 | 15 | 11 | 13 | 0 | 1 | 6 | 7 | 4 | 4 | 2 | 3 | 2 | 3 | 3 | 5 |
| Nebraska | 64 | 53 | 8 | 9 | 9 | 15 | 20 | 13 | 30 | 32 | 0 | 0 | 9 | 9 | 6 | 4 | 2 | 0 | 2 | 4 | 14 | 13 |
| New Hampshire | 475 | 385 | 18 | 22 | 21 | 20 | 20 | 17 | 21 | 14 | 1 | 1 | 9 | 6 | 3 | 4 | 2 | 3 | 2 | 3 | 5 | 10 |
| New Mexico | 47 | 163 | 81 | 88 | 15 | 12 | 4 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| New York | 408 | 366 | 13 | 16 | 18 | 19 | 24 | 19 | 20 | 19 | 0 | 1 | 7 | 8 | 5 | 5 | 4 | 4 | 2 | 2 | 7 | 7 |
| Oregon | 305 | 290 | 7 | 7 | 14 | 15 | 22 | 20 | 23 | 21 | 1 | 1 | 9 | 10 | 3 | 4 | 3 | 2 | 3 | 3 | 15 | 16 |
| South Carolina | 34 | 29 | 3 | 3 | 0 | 7 | 3 | 7 | 18 | 7 | 0 | 0 | 12 | 10 | 15 | 10 | 6 | 7 | 12 | 0 | 32 | 48 |
| Utah | 36 | 36 | 14 | 11 | 17 | 17 | 25 | 42 | 36 | 17 | 0 | 3 | 6 | 6 | 0 | 0 | 0 | 3 | 0 | 0 | 3 | 3 |
| Vermont | 159 | 151 | 10 | 11 | 19 | 22 | 25 | 15 | 21 | 21 | 0 | 3 | 10 | 13 | 4 | 6 | 4 | 3 | 2 | 2 | 5 | 5 |
| Washington | 119 | 116 | 11 | 11 | 14 | 10 | 18 | 22 | 29 | 28 | 0 | 2 | 11 | 13 | 6 | 3 | 3 | 3 | 2 | 3 | 8 | 4 |
| Wisconsin | 1,531 | 1,457 | 26 | 25 | 20 | 19 | 20 | 19 | 18 | 18 | 0 | 1 | 7 | 6 | 2 | 3 | 2 | 2 | 1 | 1 | 4 | 6 |
| Total | 13,597 | 13,220 | 19 | 20 | 16 | 15 | 20 | 18 | 19 | 19 | 1 | 1 | 7 | 8 | 4 | 4 | 3 | 3 | 2 | 2 | 9 | 10 |

Source: State Annual Buy-In Report Forms for 2004.

Note: The data above are for individuals enrolled in the Buy-In for the entire fourth quarter of 2004 and for the entire fourth quarter of 2003. California, Indiana, New Jersey and Pennsylvania did not submit these data. Four states (Louisiana, Michigan, North Dakota, and West Virginia) did not submit these data because their programs did not begin until 2004.

[a]Percentages calculated among participants with UI earnings.

**Table D.19: Mean Monthly UI Earnings in 2002 and 2003, by State**

| State | Total Participants with Earnings | | Earnings Categories[a] | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | $1-200 | | $201-400 | | $401-600 | | $601-800 | | $811-1000 | | $1001-1200 | | $1201-1400 | | $1401-1600 | | $1601+ | |
| | 2003 | 2004 | 2003 | 2004 | 2003 | 2004 | 2003 | 2004 | 2003 | 2004 | 2003 | 2004 | 2003 | 2004 | 2003 | 2004 | 2003 | 2004 | 2003 | 2004 |
| Alaska | 20 | 19 | 5 | 5 | 0 | 0 | 10 | 5 | 30 | 26 | 5 | 5 | 10 | 11 | 15 | 5 | 0 | 0 | 25 | 42 |
| California | 272 | 254 | 14 | 13 | 10 | 11 | 25 | 20 | 21 | 19 | 9 | 13 | 6 | 6 | 3 | 4 | 1 | 3 | 11 | 12 |
| Connecticut | 1,056 | 891 | 7 | 9 | 20 | 19 | 29 | 22 | 24 | 25 | 6 | 11 | 4 | 3 | 3 | 2 | 1 | 2 | 7 | 9 |
| Illinois | 84 | 75 | 11 | 15 | 13 | 19 | 32 | 29 | 32 | 27 | 6 | 5 | 0 | 1 | 1 | 1 | 5 | 1 | 0 | 1 |
| Iowa | 1,315 | 1,066 | 27 | 32 | 22 | 22 | 21 | 19 | 18 | 15 | 5 | 5 | 2 | 2 | 1 | 1 | 1 | 1 | 2 | 2 |
| Kansas | 251 | 233 | 22 | 17 | 31 | 31 | 26 | 24 | 16 | 15 | 4 | 8 | 2 | 3 | 0 | 1 | 0 | 0 | 0 | 2 |
| Maine | 345 | 326 | 4 | 5 | 10 | 10 | 19 | 12 | 20 | 22 | 11 | 15 | 7 | 4 | 7 | 4 | 5 | 6 | 17 | 22 |
| Massachusetts | 2,107 | 1,837 | 4 | 5 | 9 | 9 | 19 | 16 | 19 | 20 | 6 | 7 | 5 | 4 | 5 | 4 | 6 | 5 | 27 | 29 |
| Minnesota | 2,491 | 2,378 | 23 | 22 | 18 | 19 | 23 | 20 | 21 | 22 | 6 | 7 | 2 | 2 | 2 | 2 | 1 | 1 | 4 | 5 |
| Missouri | 878 | 815 | 28 | 31 | 21 | 19 | 23 | 20 | 15 | 13 | 5 | 6 | 4 | 4 | 2 | 3 | 1 | 1 | 2 | 2 |
| Nebraska | 52 | 46 | 2 | 7 | 4 | 7 | 25 | 26 | 31 | 22 | 10 | 11 | 6 | 7 | 2 | 0 | 4 | 7 | 17 | 15 |
| New Hampshire | 485 | 432 | 21 | 22 | 23 | 26 | 25 | 18 | 16 | 17 | 5 | 9 | 3 | 2 | 3 | 2 | 1 | 2 | 3 | 3 |
| New Mexico | 48 | 45 | 13 | 4 | 2 | 7 | 21 | 0 | 23 | 0 | 15 | 0 | 6 | 2 | 2 | 4 | 2 | 9 | 17 | 73 |
| Oregon | 231 | 229 | 10 | 7 | 12 | 14 | 18 | 19 | 18 | 18 | 6 | 10 | 7 | 4 | 3 | 4 | 5 | 3 | 22 | 20 |
| Utah | 30 | 27 | 23 | 19 | 13 | 26 | 40 | 19 | 13 | 30 | 7 | 7 | 0 | 0 | 0 | 0 | 3 | 0 | 0 | 0 |
| Vermont | 146 | 145 | 14 | 13 | 21 | 19 | 23 | 23 | 27 | 21 | 5 | 12 | 4 | 3 | 1 | 3 | 2 | 2 | 3 | 5 |
| Washington | 82 | 75 | 16 | 16 | 22 | 15 | 15 | 19 | 29 | 24 | 10 | 11 | 2 | 4 | 2 | 3 | 0 | 0 | 4 | 9 |
| Wisconsin | 1,218 | 1,146 | 26 | 27 | 19 | 19 | 23 | 19 | 18 | 19 | 5 | 7 | 2 | 2 | 2 | 2 | 1 | 1 | 4 | 4 |
| Total | 11,111 | 10,039 | 17 | 18 | 17 | 17 | 23 | 19 | 20 | 20 | 6 | 8 | 3 | 3 | 3 | 2 | 2 | 2 | 9 | 10 |

Source: State Annual Buy-In Report Forms for 2003.

Note: The data above are for individuals enrolled in the Buy-In for the entire fourth quarter of 2003 and for the entire fourth quarter of 2002. Data for Indiana and Pennsylvania are not included because they did not use the UI system, thus rendering their data non-comparable with other states. New Jersey did not submit these data. New York's program did not begin until 2003, and programs in the following states did not begin until 2004: Louisiana, Michigan, North Dakota, and West Virginia. Two states (Arkansas and South Carolina) had programs in 2003 but did not have a Medicaid Infrastructure Grant and thus did not submit data.

[a]Percentages calculated among participants with UI earnings.

**Table D.20: Mean Monthly UI Earnings in 2001 and 2002, by State**

| | Total Participants with Earnings | | Earnings Categories[a] | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | $1-200 | | $201-400 | | $401-600 | | $601-800 | | $811-1000 | | $1001-1200 | | $1201-1400 | | $1401-1600 | | $1601+ | |
| State | 2003 | 2004 | 2003 | 2004 | 2003 | 2004 | 2003 | 2004 | 2003 | 2004 | 2003 | 2004 | 2003 | 2004 | 2003 | 2004 | 2003 | 2004 | 2003 | 2004 |
| Alaska | 30 | 28 | 7 | 4 | 10 | 7 | 20 | 25 | 17 | 18 | 7 | 18 | 13 | 14 | 7 | 4 | 3 | 0 | 17 | 11 |
| Connecticut | 774 | 669 | 16 | 20 | 19 | 16 | 26 | 25 | 21 | 21 | 7 | 7 | 2 | 3 | 2 | 2 | 2 | 1 | 5 | 6 |
| Iowa | 1,081 | 1,014 | 25 | 27 | 22 | 22 | 25 | 21 | 17 | 19 | 5 | 4 | 2 | 2 | 1 | 1 | 1 | 1 | 1 | 2 |
| Maine | 204 | 185 | 12 | 12 | 16 | 16 | 23 | 21 | 15 | 15 | 9 | 6 | 9 | 6 | 4 | 8 | 5 | 4 | 7 | 11 |
| Massachusetts | 2,108 | 1,879 | 5 | 5 | 9 | 9 | 17 | 19 | 17 | 18 | 6 | 7 | 5 | 5 | 6 | 5 | 6 | 6 | 29 | 27 |
| Minnesota | 2,440 | 2,330 | 22 | 24 | 21 | 18 | 24 | 22 | 19 | 19 | 5 | 6 | 2 | 2 | 2 | 2 | 1 | 1 | 4 | 5 |
| Nebraska | 46 | 44 | 2 | 2 | 11 | 5 | 28 | 34 | 24 | 27 | 11 | 11 | 4 | 0 | 4 | 5 | 0 | 5 | 15 | 11 |
| New Mexico | 48 | 48 | 13 | 13 | 13 | 2 | 19 | 21 | 23 | 23 | 10 | 15 | 8 | 6 | 2 | 2 | 0 | 2 | 13 | 17 |
| Oregon | 215 | 213 | 8 | 12 | 17 | 15 | 15 | 16 | 15 | 16 | 7 | 7 | 7 | 5 | 5 | 4 | 5 | 5 | 22 | 20 |
| Utah | 23 | 21 | 48 | 43 | 13 | 14 | 30 | 29 | 9 | 10 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 5 | 0 | 0 |
| Vermont | 101 | 105 | 14 | 15 | 16 | 21 | 27 | 18 | 25 | 31 | 11 | 8 | 3 | 2 | 1 | 0 | 1 | 3 | 3 | 2 |
| Wisconsin | 689 | 636 | 18 | 21 | 23 | 19 | 25 | 25 | 23 | 21 | 5 | 6 | 2 | 1 | 1 | 1 | 1 | 1 | 4 | 4 |
| Total | 7,759 | 7,172 | 16 | 18 | 17 | 16 | 22 | 21 | 18 | 19 | 6 | 6 | 3 | 3 | 3 | 3 | 3 | 3 | 11 | 11 |

Source: State Annual Buy-In Report Forms for 2002.

Note: The data above are for individuals enrolled in the Buy-In for the entire fourth quarter of 2002 and for the entire fourth quarter of 2001. New Jersey did not submit earnings data in 2002. The following states were unable to provide these data for the 2002 Annual Report because they did not have Buy-In programs for the entire 2001 calendar year: Illinois, Indiana, Kansas, Missouri, New Hampshire, New York, and Pennsylvania. Data for California were excluded because these states used sources in addition to the UI system to provide these data. New York's program did not begin until 2003, and programs in the following states did not begin until 2004: Louisiana, Michigan, North Dakota, and West Virginia. Two states (Arkansas and South Carolina) had programs in 2003 but did not have a Medicaid Infrastructure Grant and thus did not submit data.

[a]Percentages calculated among participants with UI earnings.

**Table D.21: Number of Participants Required to Pay Premiums and Co-Payments and Average Monthly Amounts, by State, 2002-2004**

| State | Total Participants | | | Percent Required to Pay | | | Average Monthly Premium ($) | | |
|---|---|---|---|---|---|---|---|---|---|
| | 2002 | 2003 | 2004 | 2002 | 2003 | 2004 | 2002 | 2003 | 2004 |
| Alaska | 186 | 179 | 173 | 49 | 63 | 65 | 43 | 13 | 35 |
| Arkansas[a] | N/R | N/R | 45 | N/R | N/R | 0 | N/R | N/R | 0 |
| California | 651 | 807 | 1,085 | 100 | 100 | 100 | 35 | 30 | 31 |
| Connecticut[b] | 2,075 | 2,505 | 2,940 | 17 | 13 | 12 | 40 | 49 | 37 |
| Illinois | 177 | 446 | 558 | 99 | 100 | 99 | 48 | 48 | 51 |
| Indiana | 2,344 | 5,006 | 5,899 | 44 | 11 | 28 | 64 | 82 | 74 |
| Iowa | 4,811 | 6,169 | 7,540 | 29 | 26 | 25 | 35 | 36 | 39 |
| Kansas | 384 | 621 | 782 | 59 | 69 | 60 | 67 | 62 | 71 |
| Louisiana | N/A | N/A | 385 | N/A | N/A | 9 | N/A | N/A | 77 |
| Maine | 617 | 733 | 591 | 16 | 12 | 6 | 12 | 13 | 13 |
| Massachusetts | 5,918 | 6,253 | 6,521 | 74 | 91 | 91 | 44 | 50 | 47 |
| Michigan | N/A | N/A | 84 | N/A | N/A | 0 | N/A | N/A | 0 |
| Minnesota | 5,932 | 6,178 | 5,731 | 83 | 97 | 100 | 40 | 44 | 56 |
| Missouri | 4,736 | 13,678 | 17,126 | 11 | 14 | 16 | 65 | 66 | 69 |
| Nebraska | 91 | 102 | 125 | 3 | 1 | 2 | 72 | 111 | 101 |
| New Hampshire | 880 | 1,110 | 1,027 | 11 | 29 | 32 | 34 | 34 | 37 |
| New Jersey[c] | 516 | 892 | 1,276 | 0 | 0 | 0 | 0 | 0 | 0 |
| New Mexico[a] | 712 | 890 | 1,155 | 0 | 0 | 0 | 0 | 0 | 0 |
| New York[d] | N/A | 617 | 2,597 | N/A | 0 | 0 | N/A | 0 | 0 |
| North Dakota | N/A | N/A | 207 | N/A | N/A | 100 | N/A | N/A | 58 |
| Oregon[e] | 531 | 565 | 543 | 2 | 2 | 51 | 30 | 45 | 103 |
| Pennsylvania | 888 | 2,196 | 3,721 | 93 | 70 | 94 | 43 | 40 | 46 |
| South Carolina[f] | N/R | N/R | 50 | N/R | N/R | 0 | N/R | N/R | 0 |
| Utah | 138 | 118 | 168 | 82 | 87 | 88 | 321 | 145 | 162 |
| Vermont[f] | 336 | 385 | 443 | 12 | 8 | 0 | 18 | 27 | 0 |
| Washington | 136 | 208 | 369 | 100 | 100 | 100 | 81 | 82 | 86 |
| West Virginia | N/A | N/A | 49 | N/A | N/A | 94 | N/A | N/A | 26 |
| Wisconsin | 3,339 | 5,165 | 7,092 | 13 | 11 | 10 | 131 | 139 | 143 |
| Total | 35,398 | 54,823 | 68,282 | 44 | 38 | 38 | 48 | 51 | 56 |

Source: State Annual Buy-In Report Form for 2002, 2003, and 2004.

Note: The data above are for individuals who were enrolled for the entire fourth quarter of the given year. Buy-In premiums above are in addition to the copayments and coinsurance typically required of indivdiauls in regular Medicaid.

[a]Arkansas and New Mexico do not require a premium but do charge copayments that are higher than those for regular Medicaid.

[b]State personnel in Connecticut noted that 2003 data may be inaccurate.

[c]New Jersey did not require participants to pay a premium because the revenue from doing so was too small to justify the administrative costs.

[d]New York did not collect premiums in 2003 or 2004 because its billing and collections system was not operational.

[e]Percentage of premium payers and the average premium for 2003 does not include individuals required to pay a premium on unearned income, bu thte percentage for 2004 does.

[f]Buy-In participants in South Carolina are not charged a premium. Premiums in Vermont were eliminated in 2004.

N/A = Not applicable. New York's program did not begin until 2003 and programs in the following states did not begin until 2004: Louisiana, Michigan, North Dakota, and West Virginia.

N/S = Not submitted. Arkansas and South Carolina had a Buy-In program in 2002 and 2003 but did not have a Medicaid Infrastructure Grant and thus did not submit these data.

**Table D.22: Average Per Member Per Month (PMPM) Medicaid Expenditures, by State, 2002-2004**

| State | Total Participants | | | Average PMPM ($) | | |
|---|---|---|---|---|---|---|
| | 2002 | 2003 | 2004 | 2002 | 2003 | 2004 |
| Alaska | 186 | 179 | 173 | 572 | 994 | 1,041 |
| Arkansas | N/S | N/S | 45 | N/S | N/S | 535 |
| California | 651 | 807 | 1,085 | 559 | 647 | 770 |
| Connecticut | 2,075 | 2,505 | 2,940 | 1,616 | 1,058 | 1,178 |
| Illinois | 177 | 446 | 558 | 575 | 641 | 709 |
| Indiana | 2,344 | 5,006 | 5,899 | 2,260 | 2,813 | 2,657 |
| Iowa | 4,811 | 6,169 | 7,540 | 722 | 786 | 835 |
| Kansas | 384 | 621 | 782 | 609 | 802 | 866 |
| Louissiana | N/A | N/A | 385 | N/A | N/A | 577 |
| Maine | 617 | 733 | 591 | 505 | 367 | 823 |
| Massachusetts | 5,918 | 6,253 | 6,521 | 441 | 605 | 582 |
| Michigan | N/A | N/A | 84 | N/A | N/A | 454 |
| Minnesota | 5,932 | 6,178 | 5,731 | 1,467 | 1,648 | 1,725 |
| Missouri | 4,736 | 13,678 | 17,126 | 950 | 1,088 | 1,045 |
| Nebraska | 91 | 102 | 125 | 605 | 679 | 700 |
| New Hampshire | 880 | 1,110 | 1,027 | 1,602 | 2,046 | 1,382 |
| New Jersey | 516 | 892 | 1,276 | 1,128 | 731 | 783 |
| New Mexico | 712 | 890 | 1,155 | 854 | 918 | 892 |
| New York | N/A | 617 | 2,597 | N/A | 1,723 | 1,189 |
| North Dakota | N/A | N/A | 207 | N/A | N/A | 2,136 |
| Oregon | 531 | 565 | 543 | 690 | 698 | 697 |
| Pennsylvania | 888 | 2,196 | 3,721 | 260 | 646 | 950 |
| South Carolina | N/S | N/S | 50 | N/S | N/S | 1,077 |
| Utah | 138 | 118 | 168 | 1,372 | 1,202 | 1,348 |
| Vermont | 336 | 385 | 443 | 980 | 1,256 | 982 |
| Washington | 136 | 208 | 369 | 551 | 516 | 589 |
| West Virginia | N/A | N/A | 49 | N/A | N/A | 862 |
| Wisconsin | 3,339 | 5,165 | 7,092 | 919 | 948 | 1,010 |
| Total | 35,398 | 54,823 | 68,282 | 1,016 | 1,176 | 1,157 |

Source: State Annual Buy-In Report Form for 2002, 2003 and 2004.

Note: The data above are for individuals enrolled during the entire fourth quarter of the given year.

N/A = Not applicable. New York's program did not begin until 2003 and programs in the following states did not begin until 2004: Louisiana, Michigan, North Dakota, and West Virginia.

N/S = Not submitted. Arkansas and South Carolina had a Buy-In program in 2002 and 2003 but did not have a Medicaid Infrastructure Grant and thus did not submit these data.

**Table D.23: Distribution of Medicaid Expenditures During the Fourth Quarter, by State, 2002-2004**

| State | Percent of Participants in Expenditure Categories | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | $0 | | | $1-500 | | | $501-1,000 | | | $1,001-5,000 | | | $5,001-20,000 | | | $20,001+ | | |
| | 2002 | 2003 | 2004 | 2002 | 2003 | 2004 | 2002 | 2003 | 2004 | 2002 | 2003 | 2004 | 2002 | 2003 | 2004 | 2002 | 2003 | 2004 |
| Alaska | 10 | 6 | 23 | 87 | 42 | 42 | 3 | 25 | 15 | 0 | 27 | 20 | 0 | 1 | 1 | 0 | 0 | 0 |
| Arkansas | N/S | N/S | 7 | N/S | N/S | 64 | N/S | N/S | 18 | N/S | N/S | 9 | N/S | N/S | 2 | N/S | N/S | 0 |
| California | 8 | 5 | 6 | 65 | 55 | 53 | 16 | 20 | 21 | 10 | 20 | 20 | 1 | 0 | 0 | 0 | 0 | 0 |
| Connecticut | 2 | 13 | 4 | 32 | 40 | 42 | 21 | 18 | 21 | 39 | 25 | 30 | 6 | 4 | 4 | 0 | 0 | 0 |
| Illinois | 7 | 3 | 0 | 50 | 42 | 0 | 27 | 22 | 0 | 16 | 29 | 0 | 1 | 2 | 0 | 0 | 1 | 0 |
| Indiana | 8 | 7 | 4 | 33 | 28 | 32 | 13 | 14 | 17 | 26 | 29 | 28 | 17 | 21 | 17 | 4 | 1 | 2 |
| Iowa | 0 | 0 | 0 | 50 | 49 | 45 | 28 | 27 | 29 | 21 | 23 | 25 | 0 | 1 | 1 | 0 | 0 | 0 |
| Kansas | 4 | 2 | 2 | 57 | 48 | 43 | 20 | 24 | 27 | 19 | 26 | 27 | 0 | 1 | 1 | 0 | 0 | 0 |
| Louissiana | N/A | N/A | 9 | N/A | N/A | 59 | N/A | N/A | 18 | N/A | N/A | 12 | N/A | N/A | 1 | N/A | N/A | 1 |
| Maine | 6 | 27 | 3 | 74 | 56 | 58 | 7 | 7 | 18 | 10 | 8 | 17 | 2 | 3 | 3 | 0 | 0 | 0 |
| Massachusetts | 8 | 6 | 6 | 67 | 61 | 60 | 15 | 17 | 18 | 10 | 15 | 15 | 0 | 0 | 0 | 0 | 0 | 0 |
| Michigan | N/A | N/A | 15 | N/A | N/A | 71 | N/A | N/A | 12 | N/A | N/A | 1 | N/A | N/A | 0 | N/A | N/A | 0 |
| Minnesota | 2 | 1 | 1 | 37 | 31 | 31 | 20 | 21 | 20 | 36 | 40 | 42 | 6 | 7 | 7 | 0 | 0 | 0 |
| Missouri | 6 | 2 | 3 | 44 | 40 | 41 | 22 | 24 | 25 | 26 | 31 | 29 | 1 | 2 | 2 | 0 | 0 | 0 |
| Nebraska | 1 | 2 | 0 | 58 | 61 | 57 | 22 | 23 | 18 | 19 | 13 | 24 | 0 | 2 | 1 | 0 | 0 | 0 |
| New Hampshire | 2 | 2 | 3 | 28 | 22 | 29 | 22 | 22 | 25 | 42 | 46 | 39 | 6 | 8 | 4 | 0 | 0 | 0 |
| New Jersey | 4 | 5 | 6 | 37 | 52 | 48 | 21 | 21 | 24 | 35 | 21 | 22 | 3 | 1 | 1 | 0 | 0 | 0 |
| New Mexico | 3 | 3 | 2 | 33 | 26 | 29 | 47 | 50 | 47 | 16 | 20 | 21 | 1 | 1 | 1 | 0 | 0 | 0 |
| New York | N/A | 12 | 1 | N/A | 34 | 57 | N/A | 17 | 20 | N/A | 30 | 20 | N/A | 7 | 3 | N/A | 0 | 0 |
| North Dakota | N/A | N/A | 0 | N/A | N/A | 22 | N/A | N/A | 19 | N/A | N/A | 55 | N/A | N/A | 3 | N/A | N/A | 0 |
| Oregon | 0 | 0 | 1 | 45 | 44 | 45 | 39 | 39 | 34 | 15 | 16 | 20 | 0 | 0 | 0 | 0 | 0 | 0 |
| Pennsylvania | 0 | 0 | 30 | 28 | 29 | 49 | 38 | 38 | 11 | 33 | 33 | 9 | 0 | 0 | 0 | 0 | 0 | 0 |
| South Carolina | N/S | N/S | 4 | N/S | N/S | 58 | N/S | N/S | 8 | N/S | N/S | 24 | N/S | N/S | 6 | N/S | N/S | 0 |
| Utah | 1 | 0 | 0 | 25 | 13 | 39 | 38 | 36 | 33 | 32 | 48 | 26 | 4 | 3 | 2 | 0 | 0 | 0 |
| Vermont | 1 | 2 | 0 | 46 | 37 | 44 | 15 | 17 | 19 | 36 | 42 | 37 | 1 | 2 | 0 | 0 | 0 | 0 |
| Washington | 1 | 2 | 3 | 65 | 56 | 55 | 20 | 31 | 27 | 14 | 10 | 15 | 0 | 0 | 0 | 0 | 0 | 0 |
| West Virginia | N/A | N/A | 4 | N/A | N/A | 55 | N/A | N/A | 24 | N/A | N/A | 14 | N/A | N/A | 2 | N/A | N/A | 0 |
| Wisconsin | 2 | 2 | 2 | 51 | 50 | 47 | 21 | 22 | 22 | 23 | 24 | 27 | 2 | 2 | 3 | 0 | 0 | 0 |

| | Percent of Participants in Expenditure Categories | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | $0 | | | $1-500 | | | $501-1,000 | | | $1,001-5,000 | | | $5,001-20,000 | | | $20,001+ | | |
| State | 2002 | 2003 | 2004 | 2002 | 2003 | 2004 | 2002 | 2003 | 2004 | 2002 | 2003 | 2004 | 2002 | 2003 | 2004 | 2002 | 2003 | 2004 |
| Total | 4 | 4 | 4 | 47 | 42 | 44 | 21 | 23 | 22 | 25 | 28 | 26 | 3 | 4 | 3 | 0 | 0 | 0 |

Source: State Annual Buy-In Report Form for 2002, 2003 and 2004.

Note: The data above are for individuals enrolled during the entire fourth quarter of the given year.

N/A = Not applicable. New York's program did not begin until 2003 and programs in the following states did not begin until 2004: Louisiana, Michigan, North Dakota, and West Virginia.

N/S = Not submitted. Arkansas and South Carolina had a Buy-In program in 2002 and 2003 but did not have a Medicaid Infrastructure Grant and thus did not submit these data.